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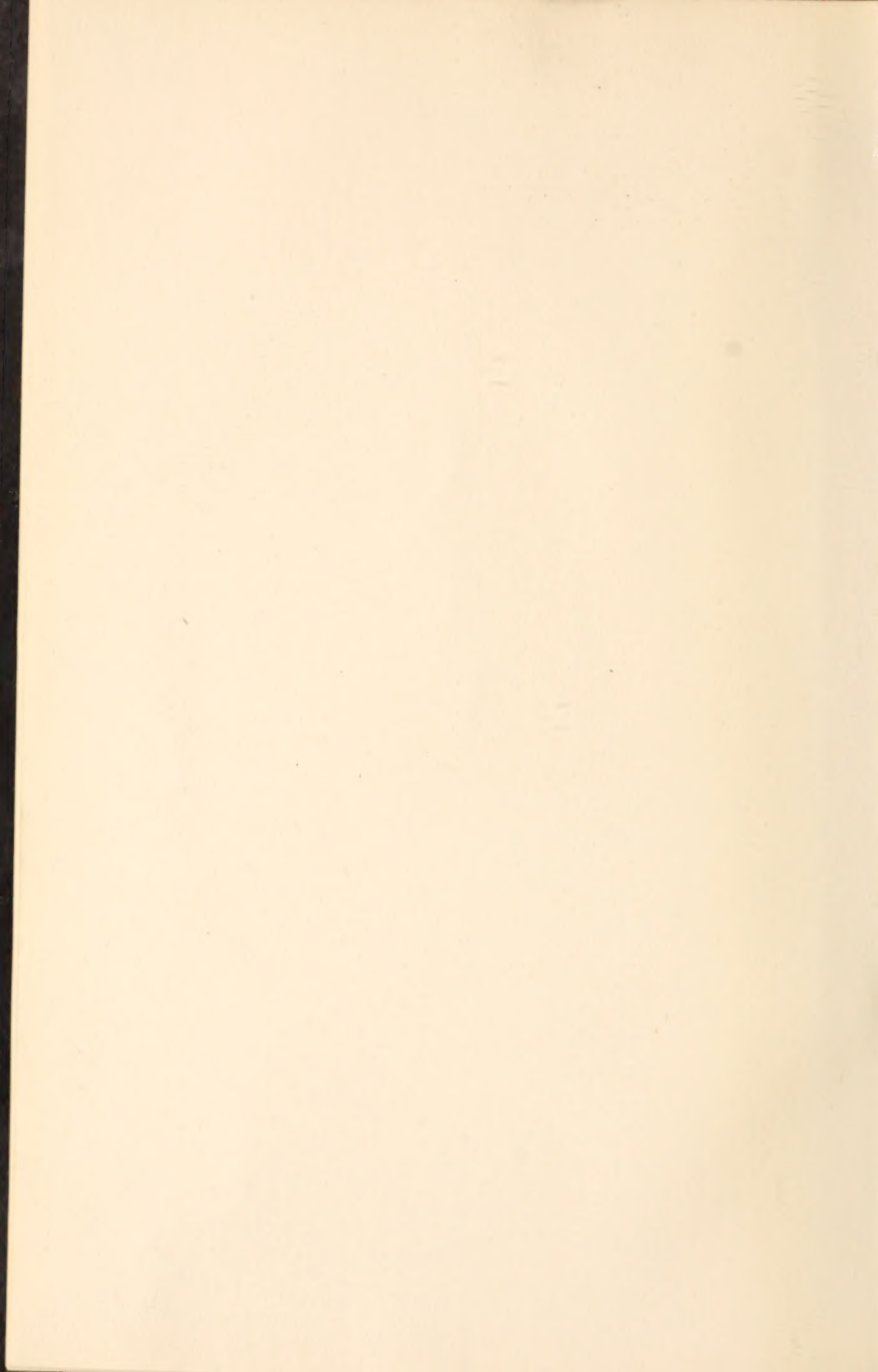














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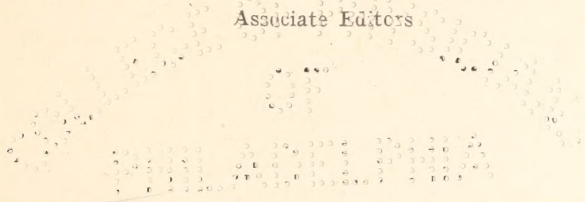
# SOUTHERN CALIFORNIA PRACTITIONER

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GEORGE H. KRESS, M.D., and F. M. POTTENGER, M.D., Assistant Editors

GEORGE L. COLE, M.D., H. BERT ELLIS, M.D., and W. JARVIS BARLOW, M.D.,  
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DR. WALTER LINDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## SYMPTOMATOLOGY OF NEPHRITIS.\*

BY GEORGE L. COLE, M.D., LOS ANGELES, PROFESSOR OF MEDICINE IN THE COLLEGE  
OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA.

I regret exceedingly that Dr. Lemke cannot be here to speak of the symptomatology of nephritis, because I know full well his ability to present it in a clear and lucid manner. However, I am just as sure that Dr. Woods Hutchinson, who is to follow me with a talk upon diagnosis, will be kind enough to correct any errors that I may inadvertently make, and to supply any omissions of which I may be guilty.

The symptomatology of nephritis is so complex that it becomes quite necessary to make some classification of the different forms. A simple division which I am in the habit of making to my class, and which I think, works out well practically, is that of 1st, Acute and 2nd, Chronic Nephritis. The Chronic forms being sub-divided into (a) parenchymatous and (b) interstitial nephritis. I think the point made by some authors in speaking of sub-chronic rather than sub-acute nephritis, remembering that the division between acute and chronic has no definite line of demarkation, is well grounded.

I am quite aware that Councilman describes an acute interstitial nephritis, occurring usually in children after fever, and I am not unaware of the fact that several other forms of nephritis have been described, but I assume this simple division as a working basis for the symptomatology, for an approximate prognosis, and to help us gain a better understanding of the disease in its complexity.

I cannot refrain from saying a word about the urinary findings, which are more or less constant in acute nephritis, showing usually a diminution in the amount, a high color, cloudiness, usually with a precipitate, a high specific gravity, much albumen, and all forms of casts and blood elements usually in abundance.

In teaching of the chronic forms, I try to impress upon my class the different urinary findings in the parenchymatous and interstitial forms. In the former, small quantities of urine of a high-specific gravity, with albumen, more or less abundant, and in the latter

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form—interstitial nephritis—large quantities of urine of low specific gravity with various forms of casts, often not abundant, and with or without albumen present, but if present, usually in small quantities.

I am again not unmindful of the recent autopsy findings to which Cabot has drawn our attention in which the postmortem work was preceded by careful urinary examination extending over weeks, months and in some cases, years. His findings would tend to reject somewhat our preconceived notions as to what we should expect to find in the kidney as a sequel to certain urinary findings. While we all have confidence in the ability and integrity of Cabot, I cannot but remember how easy it is to be led onward by enthusiasm when blazing a new path in medicine, and for one, I shall await patiently further observations in this direction before being willing to accept completely, the upsetting of the result of work which has been going on for scores of years by careful men in clinical work who have been able also to observe their cases at autopsy.

Now, in acute nephritis aside from the urinary findings, while we look upon oedema and rapid anemia as perhaps the two most constant symptoms, we must not forget Osler's remark that "the most intense acute nephritis may exist without anasarca." Furthermore we must not forget that in children the symptoms of acute nephritis may point rather to digestive derangements or brain disease than to nephritis, and thus remember the importance of careful urinary analysis in children.

It is perhaps in the chronic interstitial form that we find the complex symptomatology most marked, and it is quite impossible to get a clear understanding of the symptomatology of chronic interstitial nephritis without taking it up under the various systems of the body, such as the urinary, circula-

tory, respiratory, digestive and nervous systems, not forgetting the importance of the eye and ear under the head of special senses. I shall say nothing more of the urinary system in this connection as that I think, should more properly come under diagnosis.

But there is much to be said with regard to the circulatory system. The increased arterial tension, with the resulting arterial changes and the changes brought about in the heart itself, really form the important part of this form of nephritis. But I think it is well for us to consider it in the light in which it is viewed by Strumpell. We shall then better understand its importance. He considers the increased arterial pressure, with its result upon the heart and blood vessels, as a compensatory change. In the same manner as a hypertrophied left ventricle is a compensatory change in mitral regurgitation.

As some of the glomeruli become diseased, an increased arterial tension is necessary to procure elimination of the urinary elements through the remaining normal glomeruli. When this compensatory change becomes broken then the organism goes to pieces, as it does when the compensating heart becomes "broken."

Furthermore it is interesting to notice how Strumpell explains the fact that albumen is found in the urine sometimes, and not at others; namely, that when certain diseased glomeruli cease to functionate entirely, then the normal ones carry on the process and albumen is not eliminated. If we follow this a little further it will explain to us perhaps why a morning urine is frequently free from albumen, as that which is discharged in the morning is only what has remained in the bladder during the latter part of the night; remembering the frequency with which micturition occurs at night in this class of cases. The influence of the exertion of the previous day and of the evening



meal has passed away. Therefore the albumen is not so frequently found in the morning's urine when we have a low arterial tension, as it is in the afternoon when the arterial pressure is higher.

Considering the digestive system, I shall never forget the question which the late Alfred Loomis used to ask so frequently the members of his class as to what the first symptoms of chronic interstitial nephritis were likely to be, and woe unto the student who forgot to say "digestive disturbances." The dyspepsia, the uncontrollable vomiting, the coated, foul tongue, with breath of urinous odor, the sometimes profuse diarrhea must not be forgotten as possibilities along this line of observation.

As to the nervous system, headache, Cheyne-Stokes respiration in patients that are sometimes going about, and the possible cerebral apoplexy resulting from increased arterial tension and arterial changes are evidences which are only too frequent.

The respiratory system showing oppressed breathing, sometimes spoken of as uremic asthma, attacks of edema of the lungs, pleuritic effusions, complicating pneumonias, etc., bring a train of symptoms that must not be overlooked.

With regard to special senses, the buzzing and ringing of the ear with its annoyances, and the eye showing its changes by means of the ophthalmoscope, often lead the oculist and aurist to make the diagnosis by these symptoms alone.

Therefore, let us remember that in order to work intelligently along the lines of the symptomatology of nephritis we must not look upon nephritis as a disease having a first, second and third stage as Bright and his followers did. But that we must take some working form of classification and study the symptoms along the lines of such a classification, considering them practically as different diseases.

## TRACHOMA—ITS CAUSES AND DIAGNOSIS.\*

BY H. BERT ELLIS, A.M., M.D., LOS ANGELES. PROFESSOR OF OPHTHALMOLOGY, COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

As to the causes of trachoma the last word has not yet been said. That it is of bacterial origin there are few who doubt. Michel and Sattler claim that a micrococcus similar to the gonococcus is the particular bacterium lying behind the disease, but their demonstrations on the lower animals have not been convincing. We do know that most of the cases occur among those whose hygienic surroundings are poor and whose food stuffs are inferior in quality and scant in quantity. Most of us are of the opinion that the disease is infectious and particularly so when the

disease is accompanied by free secretion. Some claim that the discharge of a chronic blennorrhoea, if transferred into the conjunctival sac, will produce trachoma. Thus we know the disease is spread by the transfer of secretion from a trachomatous eye, and that it occurs in epidemics. That filth and crowded quarters and poor hygienic conditions are contributory causes there is but little reason to doubt. In such places as boarding schools, barracks, prisons and poor-houses, where little attention is paid to individual towels or clean linen, it is very easy to pass the

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secretion from the eyes of one person to those of another, and in hot countries such as Egypt and Italy, even the flies become common carriers. Persons of a lymphatic temperament are exceedingly susceptible to the disease. Peoples of the East, Egypt and India, and the Jews, Poles, Irish and Russians are particularly prone to the trouble. Opposed to the general rule of crowding, the American Indian is quite susceptible, while the negro race is practically free from the trouble. Elevations of over 1000 feet are practically free from the disease while it is quite common in low, moist districts. In many cases eye strain seems to be a predisposing factor.

Trachoma is characterized pathologically by the presence in the palpebral conjunctiva of numerous small circular masses; and in its course by its chronicity and by the sequelae, which are frequently of a very grave nature.

A trachomatous course may be divided for convenience sake into three stages:

First or Stage of Hypertrophy.

Second or Stage of Coalescence and Beginning Atrophy.

Third or Stage of Cicatrization or Atrophy.

Sometimes the trachomatous condition develops in the form of granules without particular discomfort to the patient, the only subjective symptoms being slightly increased secretion, not enough to glue the lids together mornings, and the lids feeling heavy from the added thickness.

More frequently however the patient complains of pain in the eyelids, which are rough and hot. Lacrimation is increased and in a few days there is some muco-purulent discharge; the ocular conjunctiva becomes injected and the cornea may become hazy. The palpebral conjunctiva is considerably thickened

and injected, with granules over the tarsal cartilages and retrotarsal folds; sometimes the conjunctiva is so much thickened that the granules are hidden for a time.

At times the onset is rapid and severe. The patient complains of the lids burning and scratching, and they become considerably swollen. There is profuse lacrimation, followed in a few days by a muco-sanguinary-purulent discharge with hypertrophy of the conjunctiva. In the course of a couple of weeks there is great thickness of the conjunctiva, the ocular conjunctiva becomes deeply injected and the periphery of the cornea becomes irritated. The first stage may last anywhere from six weeks to a year.

The granules which were separate, coalesce and cicatricial bands are formed, which by contraction decrease the conjunctival surface making the cul-de-sac shallower; the tarsi become narrower, shorter and more curved allowing the edges of the lids to rub the cornea, thus destroying the epithelium. This results in a vascular development in the cornea (pannus), ulceration of cornea with more or less destruction of the same, and the tarsal cartilages having become more curved, the lashes rub over the cornea and keep up a constant irritation. These conditions may continue for years, the cornea becoming more and more opaque and the conjunctiva reduced in area, dry and pale.

Ordinarily there should be but little difficulty in distinguishing between trachoma and vernal catarrh or the papilliform enlargements of purulent conjunctivitis, but between follicular conjunctivitis and trachoma, the differentiation is frequently decidedly difficult, the differences, however, being clinical rather than histological. Stephenson gives the chief characteristics of each as follows:

## FOLLICULAR OR FALSE GRANULATIONS.

1st. Oval or roundish, transparent bodies, the diameter of which seldom or never exceeds 1 or 1.5 millimetres. They often possess a faint-yellowish hue, and are usually arranged in rows. Their tendency is to remain discrete: that is, separate from one another. They are always larger in the inferior fornix.

2nd. Seldom are associated with much change in the structure of the conjunctiva.

3rd. Papillary hypertrophy of the upper lid is trivial.

4th. The tarsus is not implicated.

5th. The growths disappear spontaneously without forming scar-tissue.

6th. No drooping of the upper lid.

7th. Pannus and corneal ulcers are absent.

8th. Trichiasis, entropion and shrinking of the cul-de-sac do not occur.

9th. Occurs chiefly in persons under twenty years of age.

10th. Not contagious.

## "SAGO-GRAIN," OR TRUE GRANULATION.

1st. Round, opaque, ill-defined bodies of grayish color and extreme friability. Firmly and deeply imbedded in the conjunctiva, their diameter often reaching 2 millimetres or more. They tend to become confluent, thus forming areas of trachomatous material. They are always larger and more numerous in the upper fornix.

2nd. Structural changes are always present in the conjunctiva.

3rd. Papillary hypertrophy of the upper lid is marked in many cases.

4th. The tarsus is often involved.

5th. Spontaneous cure occurs only with the onset of scarring, which may be slight or extensive according to the degree of development of the original granulations.

6th. Upper lid droops in most cases.

7th. Pannus and corneal ulcers occur in at least 25 per cent. of the cases.

8th. Trichiasis, entropion, and shrinking of the cul-de-sac occur very frequently.

9th. May occur at any age.

10th. Conditionally contagious.

243-246 Bradbury Block.

## DISPLACEMENT OF THE UTERUS AND ITS TREATMENT.\*

BY J. DE BARTH SHORB, M.D., LOS ANGELES, GYNECOLOGIST, OUT-DOOR CLINIC COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

The purpose of this paper is to treat of a few of the surgical procedures for the correction of retroversion and to cite a few cases coming under my personal observation.

Uterine drainage, we recognize as of paramount importance to the health of the organ. The question of ptosis of the pelvic viscera as an accompaniment

of splanchnoptosis is fairly well understood nowadays, and we recognize the fact that ptosis may exist without any serious pathology of the organ, but that ptosis of such an organ as the uterus, cannot exist long, without producing pathological conditions is well known.

Uterine displacement as a result of fibroma, laceration of cervix uteri, in-

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terfering with its proper circulation, the impairment of the pelvic floor, etc., should be treated as separately indicated.

With the removal of the cause as our watchword, the relief of uterine displacement is apparently easy, but unfortunately we do not get the majority of our cases until the natural supports are stretched and their tonicity so far destroyed, that even with the removal of the cause of dislocation, the ligaments, so called, are not capable of performing their functions; so that in many cases of uterine displacement, (eliminating the acute, the accidental, and those of such character as are corrected by simple local treatment), we are often called upon to restore the organ to its normal position, or rather to a less pathological one and retain it by mechanical means and by so doing, to create as little pathology as possible.

In the treatment of version, the first requisite is to reduce the organ to its proper specific gravity, or place it in a condition that may lead to its complete involution and resumption of its proper place in the pelvis.

The relief of an endometritis, the removal of fibroma by myomectomy, where it is feasible, the repair of a lacerated cervix, and where the pelvic floor is at fault, restoration, as far as possible, is essential.

The question is often brought up as to what constitutes the support of the womb and holds it *in situ*.

The broad ligaments, I believe to be, in fact, the most important agents. The utero-sacral ligaments and the round ligaments essentially guy, rather directing the position of the uterus than affording any substantial support. The broad ligaments are but little more than reflections of peritoneum, but as the stomach and intestines are retained in position by their mesenteries, so, I believe, the uterus is retained by the broad ligaments. As the broad ligaments are

too deficient in muscular tissue, to trust to supporting a heavy uterus, I believe the operations on the round ligaments are the operations of choice, from the fact that a normal structure is used for the purpose of support and the muscular elements increase; *pari passu*, with the growth of the uterus in pregnancy, thereby supporting the uterus in its increased weight by a vicarious hypertrophy.

The operation of Baldy of Philadelphia of cutting off the round ligament at its uterine attachment, perforating the broad ligament and stitching the round ligament to the posterior wall of the uterus, fulfils the indication of producing an anteversion of the uterus, so that the intrapelvic pressure is exerted on the posterior surface of the uterus and holds it in position, but the objection to this procedure is that he relies upon that part of the round ligament most apt to be defective, that is, its insertion.

We often find a good round ligament tailing out at its insertion, to about the thickness of a whip cord, with so little muscle about it, that it is incapable of affording any material support. In one case I operated on by this method, I obtained a good result; fortunately the ligaments at their insertion were good, and the patient, a chronic invalid before operation, has become a trained nurse capable of performing her work with comfort. This case was rather an interesting one, from the fact that two years before doing the Baldy operation upon her, I did a Kelly utero-suspension, and although the uterus remained in position for eighteen months, it finally re prolapsed into the posterior cul-de-sac and during the entire period from the suspension of the uterus to the subsequent operation, the girl complained of constant dragging on the anterior abdominal wall and as an evidence that traction actually existed, there was a marked dimpling at the point of fixa-

tion. On re-opening the abdomen, I found a long, thin adhesion stretching from the abdominal wall to the uterus, the organ occupying the position for which the prior operation had been done to relieve.

The operation of Noble of Atlanta, Georgia, and the modifications of Wylie's, such as suggested by Gilliam, are efficient operations, and I believe will fulfill the indications in the majority of cases; Gilliam's operation, having the advantage of laparotomy, affording us an opportunity to explore the pelvis and doing what operation may be indicated, on the tubes and ovaries, and of also freeing adhesions, which in long standing cases so often exist. I have found the precaution necessary, or rather a modification of Gilliam's operation advisable. This was demonstrated to me in the first case I operated on by this method. I followed the description of technique given by the author, and obtained an unsatisfactory result; the woman suffered more discomfort from the abnormally low position of the uterus, with marked anteversion, than she did with her retroversion, for which the operation was instituted. I attributed this to the fact that I made my perforations in the aponurosis too low and drew the uterus down, and forward, where suspension was indicated. The patient's condition was such as to justify further interference. I opened the abdomen after six months; cut off the round ligaments at the attachments I had created and fastened them higher on the abdominal wall, so that the uterus

was suspended and occupied, almost a vertical position in the pelvis. With the mattress suture, I then tacked a fold of the broad ligament to the posterior wall of the uterus, producing a slight anteversion and shortening up the broad ligament by so doing. My results were satisfactory; the uterus now occupies a good position, is freely movable and my patient is comfortable.

With three cases on which I have done Gilliam's operation since, I have pursued the policy of suspending the uterus by the round ligament, making the perforations higher in the aponurosis than prescribed by the author of the operation, but not so high as to convert the womb into an intra-abdominal organ, but to draw it well up in the pelvis and then utilize a fold of broad ligament fastened to the posterior wall to produce a slight anteversion, so that intrapelvic pressure is exerted on the back of the uterus, thereby preventing a tendency to retro-displacement and at the same time shortening up the broad ligament and bringing it into play as an aid to support.

Among the multitude of names applied to operations, with their chances of confusion, I will briefly state that Gilliam's consists of a laparotomy, then finding and freeing the round ligament and drawing it through a perforation in the aponurosis to either side of the rectus abdominis muscle and fastening the ligament to the anterior surface of the aponurosis of the external oblique muscle.

## THE "WORM DOCTOR" FAKE.\*

BY ANSTRUTHER DAVIDSON, M.D., LOS ANGELES, CAL.

The specimens of worms here shown were supposed to have been passed by a patient of mine as the result of treatment, given by a well advertised "Worm Doctor," of this State.

This patient being in somewhat indifferent health, on the advice of a friend consulted this "Worm Doctor." After due examination the "Doctor" said he had worms, and promised to convince

\*Read before the Southern California Medical Society at its Thirty-fifth Semi-Annual Session, December 6th, 1905.

him by the production of them. If he could not, he would not charge him anything; but, if he did, he would cure him for a certain sum, and guarantee to cure him any time if they returned in the next five years. This seemed a reasonable offer so he agreed to take the treatment.

This latter was conducted as follows: About noon-day a small glass of dark coloured liquid was administered and he was told to return at 5 p.m. At that hour another glass of the liquid was given. A fountain syringe was then ostentatiously cleansed and filled with warm water in his presence, a glass of medicine was added thereto and the whole administered in the form of an enema. The amount introduced was so considerable, that he had to get very hurriedly to the vessel. The enema acted freely and to his horror it seemed that five hundred worms were wriggling around in the vessel. Probably there were fifty. At all events, he secured half a dozen and these are here shown you. It requires no specialists to tell you, that these are strange worms to be passed by a human being. I thought they were the larvae of the common blue-bottle fly, but to make certain I sent them to the Smithsonian Institution with a note saying they were supposed to have been passed in the bowel movements of a patient.

The reply of Dr. Howard, Director

of the Entomological Department will interest you:

Dear Dr. Davidson:

"Referring to your letter of the 3rd instant, addressed to Mr. Coquillett and accompanying larvae said to have been passed by a patient, I would reply as follows:

"Mr. Coquillett thinks that the larvae is *Musca domestica*, and I have submitted it also to another expert assistant who says that it is undoubtedly a *Musca*. As you no doubt knew, *Musca domestica* (the common house fly,) will oviposit abundantly in human excrement, and the evidence must be very careful before we can accept the statement made in your letter. There is no record of these larvae having been passed from the alimentary canal of a human being."

"Yours most truly,

L. O. HOWARD,  
Chief of Bureau."

The "worms" were probably introduced into the chamber when the enema was administered, and so adroitly has this been managed that for years this fakir has been producing "worms" from the gullible public all over California.

The "Doctor" informed this patient that these were "liver worms" and this was probably true, as they are as conveniently and freely produced in a piece of putrid liver as in any other medium.

## SPLENOPTOSIS.\*

BY H. E. B. MONTGOMERY, M.D., LOS ANGELES, CALIFORNIA.

In reporting this case to the members of the Society, I am under grateful obligations to Dr. Claire W. Murphy for his assistance in the case, and also Dr. Frank D. Bullard, our president, for asking for the report as a special clinical case, and exhibit the spleen and patient before you.

### Report of Case:

#### HISTORY.

Mrs. F. P.—housewife, age 47. Born in a malarious district in Ill. Has had 14 attacks of chills and fever, and for 18 years never free from bilious attacks. I was called to attend patient Aug 15. Complained of pain and ten-

\*Read before the Thirty-fifth Semi-Annual Meeting of the Southern California Medical Society at Los Angeles, December 7th, 1900.



derness in left hypochondrial region. Very nervous, not able to stand on feet. Very weak, persistent vomiting, anemic. Pain severe at times. Cramping, paroxysmal in character, and chiefly in the left hypochondrium. Respiration restrained and shallow, abdomen hyperesthetic and quite tympanitic, bowels constipated and urine scanty.

Gastric disturbance continuous, a dragging pain continually in the epigastric and left hypochondriac regions.

She was thin and gaunt and occasionally jaundiced due to the obstruction of the common duct through traction on the pancreas.

Temperature 102, pulse 95.

#### EXAMINATION.

When I first examined the woman, I found her much emaciated, had been ill about three weeks, been in bed over one week.

Temperature 101, pulse rapid. Complained of pain in pelvic region, had vomited, when first taken ill and had chills.

On vaginal examination found mass in cul-de-sac, very tender. She had a leucorrhœal discharge. In the left groin was a large, painful, tender non-suppurating bubo. The history seemed that of pelvic abscess. The previous history of malaria was not elicited at that time.

I called in Dr. Claire W. Murphy in consultation Aug. 21, and decided to have patient removed to Hospital, Aug. 22, 1905, and prepared for laparotomy. Operation was performed Aug. 23, assisted by Dr. Claire W. Murphy and Dr. M. M. Armstrong.

After the abdomen was opened, I found the mass in the cul-de-sac to be the spleen. The pedicle was twisted three times. The vessels were much dilated. The vessels were ligated with No. 2 catgut as close as practicable to the spleen and then the organ was removed. She made an uneventful recovery.

Splenectomy was performed rather than splenorrhaphy because the twist in the pedicle was of such a nature that gangrene of the spleen was threatening. Splenorrhaphy is an operation on trial now.

Patient was given, upon the operating table, 500 C. C. Saline Sol. before finishing the operation. Temp. 99, Pulse 76, very little shock.

Blood examination was made 12 hours after operation, by Dr. E. L. Leonard, City Bacteriologist; showed no malarial organisms. Red corpuscles per Cu. M. M. 4,405,000. White Corpuscles per Cu. M. M. 9,000. Haemoglobin 65 per cent.

Second blood count taken Sept. 1, showed Red Corpuscles per Cu. M. M., 4,000,000; White Corpuscles per Cu. M. M., 25,000; Haemoglobin, 75 per cent.

Third blood count taken Oct. 12, 1905, just 42 days after operation, showed: Red Corpuscles per Cu. M. M., 4,990,000; White Corpuscles per Cu. M. M., 9,800; Haemoglobin 95 per cent.

Practically a normal condition of the blood. No malarial organisms.

The patient left the hospital the 15th day; made uninterrupted recovery.

The mortality in Splenectomy has been lessened in recent years. Possibly due to the improved technic, and to proper restriction regarding the cases which are operable. Prognosis is good in operation for floating, and fairly good in ruptured spleen.

The pathology of splenotomosis or wandering spleen, is very little spoken of in text books.

The traction upon the phreniosplenic ligament is greatest, and may rupture the suspensory ligament.

The weight of the organ exerts traction upon the stomach, duodenum, pancreas, and bile-duct. The tail of the pancreas has been found drawn into the pelvis by the spleen, and it may cause uterine displacement by its presence in the pelvis. With descent there is a

tendency to rotation of the organ. The mechanism of the rotation is probably due and explained by peristaltic action of the intestines and gravity in changing posture of the individual. It has been found rotated upon its pedicle by six turns. The effects of rotations are chiefly due to strangulation of the circulation of the spleen and pancreas. Slight constriction effects the venous circulation leading to enlargement with liability to rupture. Gangrene and peritonitis would result, as was sure to follow in this case.

Wandering spleen is acquired, not congenital. It is rarely met with in men, frequently observed though, in multiparous women.

A displaced spleen was diagnosed by Polk as a pelvic abscess.

Klein records a case, floating spleen found in the vesico-uterine pouch. It had been diagnosed as anteversion of the uterus and a pessary was found in the vagina at the operation.

Schwartz removed a wandering spleen from a woman 30 years of age, in the fifth month of pregnancy, and gestation was not interrupted.

The spleen I now exhibit, according to Dr. E. L. Leonard, is about three times larger than a normal spleen for an individual her size and weight.

The patient has improved rapidly in health, and is doing her own house work.

She has gained fourteen pounds since the operation, now nearly four months ago. She is now present in the hall.

## TWO PIONEER DOCTORS OF LOS ANGELES.\*

BY H. D. BARROWS, ESQ., LOS ANGELES.

In turning over to the Historical Society the accompanying brief historical document, (which I lately received from Ex-Sheriff Wm. R. Rowland,) containing the signatures of four early physicians of Los Angeles, I have thought that some account of two of the signers whom I knew quite well,

would be of interest to the members of our Society.

The document referred to, which Ex-Sheriff Rowland found among old papers of the Sheriff's office, was a public notice or "Aviso" of the scale of charges, (in Spanish,) by the doctors of that period, (January, 1850,) for their professional services, as follows:

### Aviso.

A la junta de la Facultad de Medicos de Los Angeles, Enero 14th, 1850, la siguiente lista de precios era adoptado:

Art. 1. Por una prescripcion en la oficina .....	\$5.00
Art. 2. Por una visita en la ciudad de dia.....	5.00
Art. 3. Por una visita en la ciudad de noche.....	10.00
Art. 4. Por una visita en el campo par cada legua.....	5.00
Art. 5. Por una Sangria .....	5.00
Art. 6. Por cada aplicacion de Ventosas .....	10.00

Firmamos nuestros nombres al antecedente

[Firmados.] CHAS. R. CULLEN,  
A. I. BLACKBURN,  
J. W. DODGE,  
GUILLERMO B. OSBORN.

### (Translation.)

#### Notice.

At a meeting of the Medical Faculty of Los Angeles, January 14, 1850, the following list of prices was adopted:

Art. 1. For an office prescription .....	\$5.00
Art. 2. For a day visit within the city .....	5.00
Art. 3. For a night visit within the city .....	10.00
Art. 4. For a visit in the country, for each league .....	5.00
Art. 5. For bleeding .....	5.00
Art. 6. For cupping .....	10.00

We subscribe our names to the foregoing

[Signed.] CHAS. R. CULLEN,  
A. I. BLACKBURN,  
J. W. DODGE,  
WM. B. OSBORN.

\*Read before the Southern California Historical Society, December 31st, 1903.

Dr. Guillermo B. Osbourn, one of the signers, who was a native of New York, came to California in 1847 in Col. Stevenson's regiment. He established the first drug store in Los Angeles in 1850, which was succeeded in '51 by that of McFarland and Downey. Daguerreotypes were first taken in Los Angeles by Dr. Osbourn and Moses Searles, on Aug. 9, 1851. In fact Dr. Osbourn's versatility was something remarkable. It is not easy to recount all the official positions he filled, or the numerous important public functions he performed. In those early days immediately after the change of Government, by means of his rare intellectual ability, together with his knowledge of the Spanish language, he made himself a very useful citizen in various capacities. When, as often happened in that period, an acquaintance with Spanish was a necessity, he often acted as Deputy Sheriff. In 1853 he was appointed Postmaster of this city by President Buchanan. In 1855 he projected the first artesian well in Southern California, at the foot of the hills not very far from the present junction of First street and Broadway. It reached a depth of about 800 feet in June, 1856, being still in blue clay, when it was abandoned for want of funds.

In 1852 fruit grafts of improved varieties had been introduced by Mayor J. G. Nichols. In 1855 Dr. Osborn imported from Rochester, a grand collection of roses and other choice shrubbery as well as many varieties of the best American fruit trees, which up to that time were almost unknown here. He was the first, too, in October, 1854, to ship East, fresh Los Angeles grapes, which were exhibited and commanded admiration at a meeting of the business committee of the New York Agricultural Society at Albany. And it is worthy of mention in this connection, that as late as November, 1856, when Matthew Keller sent a like specimen, it was almost doubted that the U. S. Pa-

tent office, "if such products were common in California."

Henry Osbourn, a son of the doctor by his first wife, was for years and until recently, an interpreter in our local courts. He lost his life through an accident not very long ago.

Dr. Osbourn's second wife, who was a native Californian, is I believe, still living in this city.

Dr. Osbourn with all his versatility, was not always overscrupulous as to the means he sometimes employed in carrying out his schemes. He once recounted to me, without even a semblance of self reproach, but on the contrary with a palpable chuckle because of his success, how he took an active part on a certain occasion in a political contest. Sometime in the early '50's, when an election was on for a State senator, and San Bernardino was a part of Los Angeles county, he was exceedingly anxious to carry the precinct of Agua Mansa which was mostly settled by Mexicans, who knew very little or no English. So he went to the Padre who had more influence in his parish than any other person, and used his most suave methods of electioneering with the Dominie in behalf of his candidate; and then to clinch the matter, he asked the Padre to pray for the repose of the soul of his mother—who was then alive and well in New York State. And on the next feast day the wily doctor was on hand at the church and on his knees, joining the Padre and his flock, in praying for the repose of his mother's soul. He added with just a shade of exultation, that his candidate was elected.

Drs. Blackburn and Dodge, two other signers of the accompanying document, I was not acquainted with.

Dr. Charles R. Cullen I knew intimately, as he was my room-mate for a considerable portion of the time, from my arrival in Los Angeles in 1854, till he left for his home in Virginia in the latter part of '56.



Dr. Cullen was a native of Virginia and a graduate of Brown University. He and his brother John came to California soon after the discovery of the mines. The doctor was a cultivated and genial gentleman whom all who made his acquaintance, could not help liking. The Spanish-speaking portion of our community of that period were especially attached to him, both as a sympathetic friend and as a physician; and for years after he went away, I remember that if his name was mentioned in the presence of those native Californians who had made his acquaintance, they would invariably manifest pleasure at the recall of his memory and would exclaim: "Ay Don Carlos! donde esta el?" or, "Que buen hombre era!" or similar expressions of kindly feelings towards him.

When the *San Francisco Bulletin* was established, Mr. C. O. Gerberding, (father of several persons of that name in California, and also I believe of Mrs. Senator Bard,) was the business manager, and James King, of William was the brave and accomplished editor. Mr. Gerberding and Dr. Cullen had been old friends in Richmond, before they came to California; and as the management of the paper desired to have a permanent resident correspondent at Los Angeles, they entered into an engagement with Dr. Cullen to fill that position paying him at the rate of ten dollars a column. Late in November, '56, Dr. Cullen concluded to return East, and stopping on his way, at San Francisco, it appears he recommended me, without my knowledge, as his successor as correspondent of the *Bulletin*; and accordingly he wrote me at their request, asking me to keep up the correspondence, on the same terms, etc., which I did for several years thereafter, writing generally by each semi-monthly steamer, giving a general resumé of current events in Southern California. The doctor's letters, as were mine, were headed in the columns of the *Bulletin*—

in small capitals: "*Letter from Los Angeles*"—"From Our Own Correspondent," and were signed "*Observer*." This signature, however, I soon dropped. My first letter was dated Dec. 6, 1856. I would like to add that in all my dealings with Mr. Gerberding, the business manager, I found him to be a thorough gentleman and a good friend.

Before I had any connection with the paper, the assassination of James King of William, had given the paper much prominence, and it had already become and it long remained the leading journal of the Pacific Coast. It was very ably edited ostensibly by a brother of James King, of William, but in reality by Mr. James Nisbet, a Scotchman, one of the most industrious and the finest literary journalists whom I ever had any acquaintance with. Afterwards, Dr. Tut-hill was associated with Mr. Nisbet and they made a very strong editorial team.

In 1857 I made a trip East, and I went to Richmond to visit Dr. Cullen. I found his mother and sisters and also his uncle, the widely known and venerable Dr. Patrick Cullen by whom I was very cordially welcomed. Dr. Charley Cullen was then located and practising his profession near Hanover Court House, a very few years afterwards the locality of some terrific fighting in the great Civil War.

In after years I kept up a more or less intermittent correspondence with the doctor, till his death several years ago.

Dr. Cullen was a thoroughly conscientious man and a religious man—co-operating with Parson Bland, Rev. Mr. Brier and Woods as they came and made brief stays—in all sincerity, in which he differed widely from Dr. Osbourn whose only church affiliation, so far as I knew, was that serio-comic episode at "Agua Mansa."

When the late Dr. J. C. Fletcher first came to Los Angeles, Dr. Cullen wrote me asking me to hunt him up, which I did, and I found him to be a very

cultivated and widely-traveled gentleman. He told me that he had resided for a lengthy period at Rio de Janeiro, Brazil, where he had made the personal acquaintance of Don Pedro, the vener-

able emperor of Brazil, and also that he had lived at Naples, Italy, 18 years.

Dr. Cullen and Dr. Fletcher were classmates and graduates of Brown University.

## DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M.D., EDITOR.

### EDITORIAL COMMENT.

THE IDEAL OPERATION.—The ideal operation depends as Holmes (*Amer. Med.*, Dec. 16, 1905), says, upon ideal and uncomplicated conditions. Most essential is the exclusive diagnosis. Here is an aphorism that should be emblazoned on the walls of every operating room—"Too much time is spent by the patient on his back after operation, and too little by the surgeon at the bedside and in the laboratory before the operation."

In order to make the stay of the patient short after surgical operation, he should be studied in the hospital for days or even weeks before operation is undertaken. The operating room service should be reliable, not alone in equipment, which money will buy and anyone with sufficient capital can acquire, but a permanent and trained management is absolutely essential, and few operators can secure this. The Mayo's phenomenal success is in a large measure due to this last factor. There are hundreds of hospitals with perfect material equipment but only tens with reliable operating room service and management. Holmes' experience leads him to say that whenever commercial greed, eleemosynary display, religious or national prejudices dictate hospital management, ostentatious extravagance is manifest in the operating room equipment, and niggardly parsimony or criminal ignorance in the operating room service. Every surgeon who wishes to do ideal surgery must have a corps of permanent trained and sympathetic assistants. That is, the assistants must be

in sympathy with the methods and the man who is doing the operation, and the *esprit de corps* must be marked and always in evidence. Two assistants are sufficient, more add to the danger of infection and do not help in shortening the duration of the operation. No ideal operation can be performed with assistants picked up for the occasion and unused to the operator's methods and his technical foibles. The anaesthesia must be short. All anaesthesia is attended by danger, but we all agree that a brief narcosis is less so than a protracted one. It is a fact, of course, that sudden deaths sometimes occur under chloroform, at the very first inhalation, and the malignant toxemia which occasionally proves disastrous, with the symptoms of acute yellow atrophy of the liver, does not seem to be dependent upon the duration of the narcosis. Still even in this dark corner of clinical history no one would maintain that a shorter anaesthesia was more dangerous.

Many of the dangers of surgery arise from a poorly given anaesthetic due to the lack of skill of the anaesthetizer. Here the operation is unduly prolonged, the manipulations, owing to the rigidity of the patient who is struggling, are excessively rigorous and the abdominal nerves receive dangerous concussions.

The administration of nitrous oxide gas, followed by ether, is a procedure to be fully commended.

Local anaesthesia does not receive the attention that it deserves in capital surgery. Many operators do very extensive abdominal operations with this

method. Gall bladder surgery, appendicectomy, cystotomy and abdominal operations on the uterus and adnexa have been thus performed by men of skill and repute with entire satisfaction to themselves and their patients.

Scopolamine is as yet too new to be fully understood. It is a marvelous phenomena to see patients operated upon under the profound sleep of scopolamine. If it is safe, it is a very valuable addition to our armamentarium. It seems to be analogous to hyocine and we know that that drug quiets the cerebrum and produces deep sleep in certain persons but we do not know whether the combination of scopolamine, morphine and chloroform is sufficiently established in safe grounds to be recommended. Hyocine and by inference scopolamine, produces wild delirium in some patients. The short incision may be considered as one of the dictates of good surgical judgment, but it must be large enough to give adequate access to the field of operation; this is also good surgical judgment. The opening should divide as few structures as possible and preserve the strength and integrity of the abdominal wall. One of the great advantages in the short cut lies in the short time consumed in its closure, a continuous catgut suture closes the peritoneum and two or three stronger stitches hold the fascia and muscle in place. The closure of the fat and skin then consumes but a moment longer. Another advantage of the small incision is the remote possibility of the protrusion of abdominal contents during the operation, perhaps also the danger of hernia is minimised and the chances of infection through many stitches is also decreased. The Holmes incision for appendicectomy is not more than an inch and a half long for cholecystectomy not more than three inches long, and for other typical procedure proportionately short.

The early erect position has many advantages, especially in the aged and

obese. The discomfort and dyspnoea of supination are always exacting many persons cannot evacuate the bowels or urinate while supine.

The early erect position and the short stay in the hospital, encourages early, prompt and effective surgery and thus relieves the patient of long continued suffering and the surgeon from the necessity of undertaking belated, dangerous and inefficient and deforming operations. The obscure and indefinable risk of cholelithiasis, periappendiceal peritonitis and strangulated hernia is endured by thousands who would be glad to terminate the risk by a short anaesthesia, a short incision and three or four days in the hospital.

UREMIC DERMATITIS. — Many writers have described cutaneous eruptions in connection with uraemia and with its cognate, rheumatism; as a dermatitis in the former and peliosis rheumatica in the latter for example. Chiari of Prague, (*Prag. Med. Wocht.*, 1905, p. 39), reached the conclusion in a case of chronic nephritis with stomatitis, enteritis and dermatitis (*acne et impetigo cachectica*) that the different inflammations were of the same etiology. That is, they were all uraemic and were caused by the toxic urinary poisons acting on both the skin and mucous membranes. The question of the exact chemic or toxic substances that cause this correlation of diseased manifestations is still among our unsolved problems and many difficulties are met with in endeavoring to solve it. But the association is of great interest to both Clinicians and Pathologists.

A few weeks ago it was our privilege to see such a case through the courtesy of Dr. M. L. Moore of this city.

The baby was a full term child that survived for about five weeks. Ten to fourteen days after birth it commenced to show failure of assimilation and symptoms of malnutrition specially



arose. Enteritis, dermatitis, pharyngitis, stomatitis and nephritis appeared almost simultaneously. The urinary excretion was almost nil for several days, then it would amount to ninety c.c., or one hundred and fifty c.c., in twenty-four hours. Marked uraemic symptoms arose, the child had several uraemic convulsions and was constantly in the stupid drowsy state of chronic uraemia. The dermatitis now became most severe and of an exfoliative type, with high degree of inflammatory changes. The buccal, nasal and pharyngeal mucous membranes were also extensively and very acutely involved. The child responded somewhat to the usual remedies for the uraemic state, but the urine never returned to the normal amount nor to its normal constituents. The involvement of the skin and mucous membrane became more marked, the convulsions more frequent and the urine progressively less and less, with vomiting of all food and expulsion of nutritive enema and death occurred about twenty days after the first symptoms became apparent.

#### APPENDICITIS IN CHILDREN.

—C. C. Barrows says that the ordinary rules for the management of a case of appendicitis cannot always be depended upon as a safe guide in cases occurring in children. Children with a beginning appendicitis almost invariably suffer from abdominal pain, usually referred to the region of the umbilicus, from nausea, as a rule, accompanied by actual vomiting and constipation. The patients have a great dread of being touched or moved. They usually lie on the back with the right thigh flexed and almost from the beginning there is well marked rigidity of the abdominal muscles. The question of temperature is not of great importance; the increased and increasing pulse rate, together with a more rapid respiration, being of vastly more concern than temperature. At times we find appendicitis

in children ushered in by a well marked rigor. The author considers this a symptom of great importance. Barrows regards an increasing leukocytosis with an increase in the polynuclear cells and of the fibrin of considerable help in the establishment of the diagnosis, but in no way to be considered to the exclusion of the clinical history of the case. He believes in operating in practically every case. While an adult may be carefully watched and with the help of the subjective symptoms correctly stated, he may be tided over an acute attack and operated on in the interval; this he believes to be a dangerous course to pursue in children. (*American Medicine*, Dec. 9, 1905.) We wish to unqualifiedly endorse the statements of Barrows—There is no more dangerous advice in all medicine than counseling delay in appendicitis in children. In our experience the disease is much more apt to be grave in the young than in the adult and in those instances in which it is ushered in by a chill gravity is always imminent. We also regard the question of temperature of little importance; in most of our very grave cases it offered but little aid in elucidating the problem. The early rigidity of the abdominal muscles, the initial chill, the nausea and vomiting, the flexed right thigh and the dread of being touched and moved have all been in our experience almost pathognomonic in appendiceal involvement in children.

#### REVIEW OF THE LITERATURE.

ECTOPIN TESTIS.—Thurston, (*Lancet*, Nov. 4, 1905, p. 1329). The patient was a Bengali child, aged five years. He was an orphan and was an inmate of a missionary home and the condition now to be described had only just been noticed. He was himself unable to give any information as to whether the testicle had always been in that position.

On examination the right testicle was situated at the root of the penis. It was equal in size to the left one, appeared normal in every respect, and was freely moveable, but after being displaced by manipulation it always returned to its original position. The right side of the scrotum was well developed. On April 18th, the testicle was exposed by an oblique incision, beginning at the external ring and extending half way down the length of the scrotum. It was found to be well formed and the tunica vaginalis was of the normal size and was closed. It was connected to the surrounding tissues by a few loose adhesions, without any recognisable attachment of the nature of a band which might possibly have been a remnant of the gubernaculum. After the separation of these adhesions it was easily brought down to the bottom of the scrotum and fixed there by a few silk sutures. The wound healed by primary union and the boy was discharged from the hospital at the end of ten days. The interest of the case lies in the extreme rarity of the condition.

#### CONGENITAL PIGMENTATION.

Dr. G. A. Sutherland exhibited to the Clinical Society of London, Oct. 27, 1905, a Japanese infant showing the Congenital Pigmentation of Mongolians. The patient was a female infant, aged ten months, of pure Japanese descent. Over the scalp the hair was long, straight and black, and it extended as a soft, downy growth over the forehead and in front of the ears. The skin over the lower part of the sacrum was of a dark blue colour and a similar pigmentation, but of a lighter colour, extended over the buttocks. Smaller areas of blue pigmentation were present along the spine and behind the left shoulder, and there was one patch on the dorsal surface of the left hand. Mr. George Pernet agreed that it was a typical example of Mongolian pig-

mentation. Histologically it had been shown that the pigment was in the corium, not in the superficial layers of the derma. It was said to disappear in some instances about the second year. Apes presented a similar discolouration in the posterior parts and this Mongolian pigmentation might be a relic of our primate progenitors.

**OE SOPHAGOTOMY IN A FIVE YEAR OLD CHILD.**—Mr. Rigby exhibited this case to the Hunterian Society, Oct. 25, 1905. It consisted of a small Metal Bicycle, measuring one and three-quarter inches by one inch, which had been impacted in the oesophagus of a child five years of age, successfully removed by oesophagotomy. An x-ray photograph was shown.

**VAGINAL CYSTS.**—Vouturiez reports a case of this nature. The patient, a woman twenty-five years old, had given birth three months previously to a well formed child. The labor was normal. A month later the presence of a small tumor in the vagina was discovered. On inspection it was found that the vulvar orifice was filled up with a round swelling. The growth was semi-transparent, of a red color, and the visible part was as large as a nut. The base of the tumor was attached to the antero-lateral wall of the vagina. The tumor was sessile. Under general anaesthesia the cyst was removed. It proved to be the size of a pigeon's egg. The writer in giving a resume of the characteristics of such growths states that they are generally found in young women after delivery. They probably develop during pregnancy. However, they have been observed in small children. The cause is generally attributed to the renewal of vital activity in the debris of the Wolffian body. These vaginal cysts are single or multiple. At times they are bilateral. The form is often elongated, accommodating itself to the axis of the vagina; these

growths are always behind the vulva but they may project outside. The size varies greatly. There is discomfort in walking, and during labor the vaginal cyst presents an obstacle. There is no real pain except in cases in which the cyst is inflamed and suppurating. Diagnosis is made by direct examination. The patient often believes that she is suffering from prolapsus uteri. *Rev. Francaise de Med. et de Chirurgie*, Oct. 30, 1905. *Med. Rec. Dec.* 1905.

#### PERFORATED GASTRIC ULCER WITH FATAL HEMORRHAGE FROM THE BOWEL IN AN INFANT FORTY-FIVE HOURS OLD.

—The first symptom in the case reported by A. G. Bisset was hemorrhage from the anus. There was no history of hemophilia, syphilis, or phthisis, and the child was not jaundiced. The bleeding continued, and the child passed into a state of collapse and died, various remedial measures being without avail. A provisional diagnosis was made of some form of ulcer pretty low down in the bowel. This was disproved by the autopsy, which revealed a typical gastric ulcer of the acute form, with clean cut, punched-out margins on the posterior stomach wall near the lesser curvature, and about half an inch from the cardiac opening. The ulcer was completely perforated, and as some shreds of mucoid material were found adhering to its peritoneal aspect, the posterior abdominal wall was again examined, and a little of this blood stained mucoid matter was seen lying in the situation which the ulcer must most probably have occupied, evidently indicating that adhesions of the ulcer had actually taken place at this point, but had become separated during the removal of the stomach from the abdomen, and had been the means of preventing the escape of the blood into the peritoneal cavity. The ulcer was circular in form and was almost the size of a three penny piece on its inner sur-

face. The paper closes with some statistics as to the frequency of occurrence of gastric ulcer in young children. The author finds that in the recorded cases actual perforation is extremely rare. In this particular case there was no vomiting whatever. Bisset refers to the origin of the lesion in his own case to the vigorous gastric peristalsis set up by the milk imbibed, though assuming that there must have been some previously weakened area on the stomach wall. For the latter he is unable to account. *Lancet*, July 8, 1905. *Med. Rec.*, July 22, 1905.

#### PYLORIC STENOSIS IN AN INFANT.

—J. L. Morse and F. T. Murphy report a case which emphasizes these facts: The symptoms may vary much from those of absolute pyloric obstruction, and they do not necessarily begin at birth. The meconium-like character of the dejections may be of great diagnostic importance. In complete or nearly complete obstruction, operation seems to offer the only hope of recovery and must be done before the infant has been reduced by starvation.—*Boston M. & S. Journal*, Nov. 2, 1905, *Am. Med.*, Nov. 11, 1905.

#### ATONY AND ASSOCIATED PATHOLOGIC CONDITIONS OF THE RECTUM AND COLON.

—Fenton B. Turck advises the use of massage and stimulation of the atonic intestine by the use of small rubber bags inserted in the rectum and sigmoid flexure, and inflated with air. The inflation can be used steadily for the desired amount of time, or the bag may be alternately relaxed and inflated again, thus producing a kind of massage of the intestine. Atony of the intestine is the result of fatigue generated by the intestine, and antitoxins may be also generated, which will restore the intestine to its normal condition. The toxins of fatigue are not dialyzable and remain where they are formed. Massage



hastens the union of antitoxins with toxin. The abdominal circulation is also an important factor in atony of the intestine, and massage by inflation stimulates the circulation. Drugs, surgery, general gymnastics, and various mechanical methods of treatment have all failed in curing atony. The introduction of air confined in the rubber bag places the amount of distention to be used under the operator's control. It may be made intermittent. Hemorrhoids, ulcers, proctitis, all are benefited as well as prolapse of the bowel, and various associated uterine conditions. The restoration of function in the intestine is permanent. *American Medicine*, Oct. 7, 1905.

**OPEN WOUNDS AS A FACTOR IN SCARLATINAL INFECTION.**—The danger of scarlatinal infection through an open wound has been quite universally recognized. In many instances, however, the cases reported as surgical scarlatina are probably erythemas due to vasomotor disturbances or to the absorption of toxic material from wound secretions. The genuine cases must be separated into those in which the infection is simply accidental, usually taking place before the wound is made, and those in which there is a true inoculation, where the wound serves as a portal of entry for the infectious material. A number of undoubted cases of the latter type are on record, among the most recent of which are two reported by Charles Herman in the *Archives of Pediatrics*, October, 1905. One little patient remained free from the disease although he was constantly among the other members of the family who were ill with scarlet fever, until he received an extensive burn of the arm.

The latter was neglected and not even covered by a protective dressing and in thirty-six hours after the injury the child developed a scarlatina which ran an ordinary course. The wound was cov-

ered with a dirty exudate, but healed as soon as the rash disappeared. The throat symptoms were not marked, and the submaxillary glands were not enlarged. In the second case the path of infection was through a vaccination wound which had been similarly neglected, and in this child the same exceptions to the usual symptoms were noted. The period of incubation in both of these cases failed to correspond with that usually assumed as characteristic of the disease, but there is no doubt that it depends very largely not only on the virulence of the contagious material and the susceptibility of the particular individual, but more especially on the place and mode of entrance of the specific contagium. It is evident from this and similar case reports that the shorter and more direct the route, the more rapidly the virus enters the circulation and the shorter the period of incubation. It also seems that although an invalid may be immune to infection in the ordinary way, he can readily contract the disease by direct inoculation through an open wound. *Editorial Med. Rec.*, Dec. 2, 1905.

**PNEUMONIC PSEUDO—APPENDICITIS.**—Méry observed this patient, a child ten years old, which was carried to the hospital with a diagnosis of appendicitis. The child complained of pain at McBurney's point. But this pain increased toward the diaphragm. There was no muscular rigidity, the abdomen being soft. The temperature was higher than that noted in appendicitis. In this case it was from 40 degrees to 41 degrees C. The facies were not typical of any abdominal trouble. On examination the presence of generalized bronchitis and pneumonia were detected. The face was red. When the diagnosis of pneumonia was made the treatment for this disease was instituted and the child soon became convalescent. The writer calls attention to

the necessity in such cases of paying careful attention to the leading symptoms. A high fever, and a congested facies ought to put the physician on his guard. Careful examination of the lungs will clinch the diagnosis, and the physician will avoid gross errors in the treatment of the case, for there are cases of this nature, on record in which operation for appendicitis has been performed.—*Journal des Practiciens*, Oct. 28, 1905. *Med. Rec.*, Dec. 9, 1905.

### REVIEW OF BOOKS.

**PRACTICAL MASSAGE IN TWENTY LESSONS.** By Hartvig Nissen, Instructor and Lecturer in Massage and Gymnastics at Harvard University Summer School; Director of Physical Training, Brookline Public Schools; Former Acting Director of Physical Training, Boston Public Schools; Former Instructor of Physical Training at Johns Hopkins University and Wellesley College; Former Director of the Swedish Health Institute, Washington, D. C., etc., etc. Author of "Swedish Movement and Massage Treatment," "A, B, C of Swedish Educational Gymnastics," "Rational Home Gymnastics," etc. With 46 Original Illustrations. 168 Pages. 12 mo. Price, Extra Cloth, \$1.00 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia.

This little book of one hundred and sixty-eight pages, divided into twenty lessons is the result of thirty years life work in massage by its well known author. It is written just as it is taught

at the Harvard University Summer School and to private classes. The methods as described are a combination of manipulations and movements, from the authorities and from personal experience and use. The book has forty-seven illustrations which are helpful and self-explanatory. Massage is comparatively new in the United States, it was hardly known in our country before the early eighties. Of course men like Mitchell, Sayre and others were using the movements sometime before this, but certainly it was but little used by the general profession before this time.

Now it has become greatly abused and misused and in many instances is used as a catch penny device of arrant quackery. It is a pleasure to see this book written along ethical and correct lines, and to see how plainly it is demonstrated that a good masseur is not the rival or opponent of the physician. It is a hearty co-operation between the physician and the massage specialist which is desirable and necessary in order to produce the best results. The book may be unhesitatingly recommended to physicians, nurses and students and to the libraries of the various training schools for nurses.

W. A. E.

## DEPARTMENTAL

### DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTENGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

#### GERMANY'S WORK IN COMBATING TUBERCULOSIS.

No nation in the world is going at the tuberculosis problem with so much earnestness as Germany. It is really fitting that this should be so, for this is the home of Koch, the discoverer of the tubercle bacillus. Here also lived Brehmer, that far seeing humanitarian who was the father of the Sanatorium

idea, founding the first institution for the cure of tuberculosis half a century ago. He was so much in advance of his confreres that they thought him insane for persisting in his belief of the curability of this disease, which had baffled medical skill during all the ages. Largely through the labors of these two men, the one demonstrating tuberculosis to be a germ disease that can be

prevented and the other that it can be cured, have the forces of the entire civilized world been directed against the great white plague.

Not only have many of the scientific problems connected with this disease been worked out in Germany, but here also has the prevention of the disease received its greatest support.

Imbued with the Brehmer idea, Germany has erected many sanatoria for the care of her people. She has 75 peoples sanatoria with 7085 beds, and 31 private institutions with 2028 beds, and still more in the course of construction.

There is one class of persons which still deserves the earnest attention of those who are building institutions of this kind, and that is the class which is not able to enter a private institution and above accepting charity, and this class was considered at the last meeting of the Central Committee for erecting Sanatoria, and it was urged that institutions be erected where a nominal sum would be charged to meet the needs of this worthy class.

The permanency of results in the sanatoria seems to be increasing. With wider experience, some of the mistakes of the earlier days of sanatorium work are being remedied and better and more lasting results are being obtained. The statistics of the Prusso-Hessian Railway Co. for 1905 shows that 53.61 per cent. of their workers who had been discharged five years were still able to do full work. This is a gain of 4.54 per cent. over the statistics of the preceding year. The statistics of Friedrichshagen Sanatorium shows of patients dismissed three and four years, 70 per cent. of the I stage, 55 per cent. of II stage and 23 per cent. of III stage are still able to work.

Great as is the humanitarian movement which prompts the erection of the German Sanatoria, where the poor afflicted with tuberculosis in its early

stages can be restored to their earning power and to the bosom of their families, it cannot compare with that other great work which has been instituted in Berlin—I refer to the "Fuersorgsstelle," or Helping Stations. In different sections of Berlin, the Committee in charge of the tuberculosis relief work, has rented apartments where the poor who suspect that they have tuberculosis can come and receive aid.

These apartments are very simple and are run in a very practical and economical manner. There is no attempt whatever at show. There are two rooms, one for a waiting room, the other for examinations. The floors are bare, the walls plain, no curtains at the windows, no furniture, except a few chairs and a table. There are one, two or three nurses attached to each one of these stations, whose duty it is to keep a careful record of every case, take the history of the patient, especially inquiring into the conditions under which the patient lives, give instructions to each patient, visit their homes and instruct them in the proper care of the sick, especially with reference to preventing the spread of the disease. In case anything is needed to increase the patient's chances of a cure or in order to prevent the spread of the disease, this is furnished by the Station. In this way patients are sent to sanatoria while they are in the early stages. Advanced cases are directed to hospitals and homes, if there is room for them; if not, they are sometimes taken away from their densely crowded quarters where there is danger of infecting their family and placed in more commodious quarters which are provided. Sometimes pillows, blankets or even beds are furnished to add to the comfort of the afflicted. Food is also given and flasks for the care of the sputum are always provided. The nurses make regular visits, seeing that the rules are being obeyed and giving new instructions when necessary.



In case one member of a family is ill, all other members are required to come to the Station for examination. In this way as many as seven different individuals in a single family have been found afflicted. This careful work, this early finding out of the presence of the disease, and this watchfulness will eventually do more to root out the disease than any other measures imaginable. It is storming the disease in its stronghold; attacking it at its source. In my entire trip in Europe, I had nothing impress me so much as this rational plan of stamping out tuberculosis. Potter, Kayserling and their helpers are certainly heroes. Their names may not be written on the scroll of fame as they would be if they had slain their fellowmen in battle, but they will be indelibly stamped in the hearts of thousands of the poor, whose homes they have blessed by relieving the great white plague of much of its terror.

I do not wish to belittle any work that has been done anywhere in combating this dread disease, yet I believe that this work in the Fuergorgs-telle" in Berlin is the most comprehensive and most practical of all the measures heretofore inaugurated for combating tuberculosis. I should like to see such organizations in every city in our country. We can stamp out tuberculosis in a reasonable time, if we go at it right. We can let it continue its ravages, if we let it alone.

#### FREQUENCY OF PRIMARY TUBERCULOSIS OF THE BOWEL IN BERLIN.

Edens (*Berliner Klinische Wochenschrift*, No. 49, 1905), reports upon the Hospital, Berlin, during the year, Oct. 1, 1904, to Oct. 1, 1905, with reference to the frequency of primary tuberculosis of the bowel. This subject is of great interest at the present time when

Age	No. of Sections from Oct. 1, 1904 to Oct. 1, 1905	No. Primary Cases of Tuberculosis of the Bowel	Of the Primary Cases of Tuberculosis of the Bowel there were affected				Total No. of Cases of Tuberculosis
			Mesenteric Glands	Mucous Membrane of the Intestine.	Serosa of the Intestine	Intestine and Mesenteric Glands	
0-1	32	..	..	..	..	..	6
1-2	12	..	..	..	..	..	4
2-3	12	..	..	..	..	..	1
3-4	11	..	..	..	..	..	..
4-5	12	2	1	..	..	1	4
5-6	6	1	1	..	..	..	2
6-7	9	..	..	..	..	..	1
7-8	6	2	2	..	..	..	2
8-9	3	..	..	..	..	..	3
9-10	1	..	..	..	..	..	1
10-11	4	1	1	..	..	..	2
11-12	2	1	..	..	..	1	2
12-13	7	4	3	..	..	1	5
13-14	1	..	..	..	..	..	1
14-15	4	..	..	..	..	..	2
15-16	1	..	..	..	..	..	1
16-20	9	1	1	..	..	..	4
20-30	61	1	1	..	..	..	24
30-40	69	3	3	..	..	..	37
40-50	78	3	2	..	1	..	28
50-60	68	3	3	..	..	..	15
60-70	52	1	1	..	..	..	19
70-80	24	2	1	..	..	1	11
80-90	7	..	..	..	..	..	1
Total	491	25	20		1	4	176
		5, 1 per ct.					35, 8 pet.

pathologists are endeavoring to discover the exact mode of entry of the tubercle bacillus into the body and also at the same time to endeavor to explain the part played by the bovine bacillus in infection.

His tables are very interesting. Table I shows that not a single case of primary tuberculosis could be reckoned before the fourth year in a material of 67 autopsies, although there were 11 cases of tuberculosis included. From the fourth to the fifteenth year there were 55 autopsies, showing 11 cases of primary tuberculosis of the bowel and 26 cases of tuberculosis. From fifteen to ninety there were 14 cases of primary disease of the bowel and 140 cases of tuberculosis in a material of 369. We are surprised to find no cases of primary tuberculosis of the bowel during the milk drinking period and so large a percentage during the period from four to fifteen. It must be remembered, however, that statistics of so few cases taken from one class of patients are very unsafe as a basis for conclusions. They are only of value in comparison with other similar statistics from other quarters. It must also be remembered that it is a very difficult matter to say with a degree of certainty that such and such a case is a primary bowel lesion. We welcome every bit of evidence, however, upon these mooted questions.

#### SOUTHERN CALIFORNIA ANTI-TUBERCULOSIS LEAGUE.

At a meeting of the Board of Directors of the Southern California Anti-Tuberculosis League held on Dec. 12th, the work of the League for the coming year was carefully considered. It was decided to endeavor to reach as many people as possible by way of talks and lectures. The advisability of giving a regular course of lectures, perhaps one each month, for the education of the laity was considered and will perhaps materialize in the near future.

The matter of a Tuberculosis Dispensary for Los Angeles was carefully considered. It is the belief of the members of the Board, that we can do more real practical work for both those afflicted and for the protection of the public, by means of a Dispensary than by any other agency, for here the poor can come and receive advice and treatment and be instructed in the methods of caring for themselves and their sputum, so as to avoid scattering infection. Such a Dispensary should be modeled after the "Fuersorgstelle" in Berlin. Let us hope that Los Angeles may soon have the good fortune to have such an institution.

The annual meeting of the League, at which officers for the coming year will be elected, will be held Thursday evening, January 25th, in the Art Room in Blanchard Hall. An interesting and profitable program is promised. Every one is cordially invited to be present.

#### A TREATISE ON DIAGNOSTIC METHODS OF EXAMINATION.

A TREATISE ON DIAGNOSTIC METHODS OF EXAMINATION. By Prof. Dr. H. Sahli of Berlin. Edited, with additions, by Francis P. Kinnelott, M.D., Professor of Clinical Medicine, Columbia University, N. Y.; and Nath'l Bowditch Potter, M.D., Visiting Physician to the City Hospital and to the French Hospital, and Consulting Physician to the Manhattan State Hospital, N. Y. Philadelphia and London: W. B. Saunders & Company, 1904. Octavo of 1008 pages, profusely illustrated. Cloth, \$4.00 net; Half Morocco, \$7.00 net.

Sahli's Diagnosis has been an authority in German speaking countries ever since the appearance of the first edition in 1894. We had often wondered why it was not translated into English and hail with delight the appearance of this translation of the new fourth German edition. This book is one of the most practical works on diagnosis that has ever been written. The author has treated the subject from the standpoint of both physiology and pathology. He has attempted to ex-

plain the whys and wherefores and make plain to the student the causes of the various phenomena under discussion. Sahli's work has always been one of the writer's favorite books. It is well illustrated, whenever the text can be elucidated by drawings. One of the most praiseworthy characteristics of the work is that it is based on the Author's own experiences. It is certainly to the credit of the Author that he refused to add a chapter on x-ray examination,

giving as his reason: "I wish to confine myself to those methods, the technic of which I am sufficiently familiar to give personal advice based on my own experience." We have no hesitancy in recommending this book to the profession, for we know that it cannot fail to become one of our standards in diagnosis. We are only sorry that it was necessary to wait eleven years after the issuing of the first edition before it was translated into English.

F. M. P.

## DEPARTMENT OF INTERNAL MEDICINE.

EDITED BY DR. DUDLEY FULTON, LOS ANGELES.

**BODILY WEIGHT AS A FACTOR IN PROGNOSIS IN NERVOUS AND MENTAL DISEASES.**—Krafft Ebing states that seldom does insanity come like a bolt out of a clear sky; much oftener its development requires months and even years. Hence the necessity to observe the early indicative signs.

Norbury (*Medical Herald*, December) says that one of the most important of these is nutritional impairment. In all forms of nervous diseases there are usually derangements of metabolism, impaired digestion, assimilation and excretion. The loss of weight goes hand in hand with conditions which impoverish the blood. The well-known loss of weight in neurasthenia, and in the acute psychoses indicate that one of the chief problems in the treatment of these conditions is the improvement of the bodily weight and nutrition.

Herter gives a practical prognostic point in acute and chronic under-nutrition, when he says in acute starvation there is danger of fatal prostration when a patient loses one-third of the normal weight, while in chronic under nutrition, as much as one-half will be tolerated, as the cells will accommodate themselves to such a loss when it is gradual.

Norbury urges full and generous feeding as one of the most important of therapeutic measures. Make the neurasthenic fat and you will have gone a long way towards making him well. Improvement in the patient's weight is usually followed by improvement in the nervous condition; on the other hand, as long as the weight falls, even if the nervous symptoms apparently are improved, we must expect long continuance of the disease.

Weight must be regularly and systematically observed in the treatment of nervous diseases.

**GASTRIC ANALYSES IN TWENTY-ONE CASES OF TABES.**—Various theories have been advanced to explain the production of gastric crises, in locomotor ataxia.

Sahli claims that the crises or some of the phenomena are dependent upon hypersecretion with hyperacidity. Similar conclusions have been reached by other observers. Ewald, in 38 cases of gastric crises found subacidity in 9, normal acidity in 9, and hyperacidity in 19 cases. In one case during a crisis, HCl was absent.

Smithwick reports the study of 21 cases (*Boston Med. and Surg. Jour.*,



Vol. 103, No. 23) and draws the following conclusions:

(1.) In *Tabes* gastric motor power and HCl and pepsin secretion are depressed more commonly than exalted.

(2.) No degree of activity of these functions characterized *tabetics*.

(3.) In gastric crises of this series HCl secretion and motor power were more depressed than usual, and in the severe painful crises depression of acid secretion was extreme and continued for hours. In one case there was probably hypersecretion of gastric juice.

**THE TREATMENT OF CHRONIC CONSTIPATION.**—Macmillan (*Medical Record*, December 16, 1905,) outlines the treatment of the above with rectal tampons, with favorable results. From a study of 200 cases he believes that about 80 per cent. were due to atony of the intestinal muscle. Peristalsis is caused primarily by the stretching of the intestinal muscularis by the contained feces.

He inserts through a protoscope a tampon—lubricated with vaseline—made of either absorbent cotton, cheese-cloth or lamb's wool. The tampon should be of sufficient size to cause some distension of the bowel. Each tampon is provided with a cord to facilitate its withdrawal. If inserted above the rectal valves, and left from two to six hours there usually occurs a copious bowel movement within a few hours.

The author in the majority of his cases has used the tampons on alternate days in the beginning of treatment and as progress was noted he increased the interval between treatments.

**GENERAL INFECTION THROUGH THE TONSILS.**—Alder in a paper before the New York County Medical Society (*Medical Record*, Vol. LXVIII, No. 24,) stated that it is not generally recognized that the tonsils serve as portals of entry of in-

fection for acute rheumatism, pleurisy, osteomyelitis, tuberculosis, general sepsis, and also of nephritis, and endocarditis.

The exposure of these organs to infection and their intimate relation to the lymph currents renders them easy sources of trouble.

An important point to remember is the recently proven fact that virulent germs may pass through the tonsillar portals without causing inflammatory reaction of them.

The most frequent infection of tonsillar origin is acute inflammatory rheumatism. Adler is convinced that muscular rheumatism is also a bacterial infection and that it enters through the tonsil. He also lays special stress upon nephritis as often resulting from and following tonsillitis. The frequent examination of the urine after nephritis is therefore urged by the author, as is also the complete eradication of enlarged and diseased tonsils whenever they are discovered, because of the dangers indicated above.

**A SIMPLE METHOD OF LOCATING THE POSITION OF THE STOMACH.**—The mechanical features of the digestive processes are justly receiving increasing attention, and study. Normal motility is undoubtedly as important to health as normal secretion of the digestive juices, particularly is this true of the stomacheic functions. While it does not follow that displacement and enlargement of the stomach always indicates that motility is impaired, yet there are perhaps in the majority of cases associated conditions. Aside from the relationship of gastroparesis and insufficient motility, the downward displacement of this viscus occasions other symptoms of importance, and the diagnosis of the condition often accounts for ill health and suffering of long standing.

While illumination of the stomach with Einhorn's diaphane, and the inflation of the stomach with gas or with air, offer accurate methods of localizing the stomach, there are in many instances objections to their use. Distending the stomach with gas is more or less dangerous from the fact that the distension is entirely without control, and several deaths have resulted from it. Both the diaphane, and the inflation with air by means of a stomach tube and a Davidson syringe bulb, required the introduction of the necessary apparatus into the stomach, which is of course a very objectionable feature to contend against in many instances.

Knapp of New York sometime ago called attention to a very simple and usually sufficiently accurate method of outlining grossly the stomach position, by having the patient drink a glass or two of cold water. Within a few minutes palpation will reveal a distinctly cold zone of the abdomen, the remaining surface of the abdomen retaining the usual bodily temperature. It is necessary of course to keep the abdomen covered to prevent a misleading chilling of the surface, before the examination.

REMARKS ON DIGITALIS TREATMENT.—All clinicians observe that the present status of digitalis therapy is far from being satisfactory. This is largely due to the fact that the active principle of the plant has not been isolated from those responsible for the

poisonous effects of the drug, and because we have no standard of known strength of the leaves. Schwyzer (*Medical News*, Vol. 87, No. 21,) in writing on the subject, says the plants vary greatly in strength, according to the location of their growth, age, etc. The dried leaves show in September a much stronger effect than the same leaves in March.

Of the three-fourths chiefly used, viz, infusion, powder, and tincture, the author considers the latter as less reliable than either of the other forms. Krehl believes the powder stronger than the infusion, containing as it does all the principles. He recommends the powder when a rapid effect is desired, infusion where a mild result is looked for.

A new principle, digitoxine introduced by Cloetta of Zurich has proven very satisfactory in cases where the ordinary preparations of digitalis failed. Schwyzer has used it extensively and if his results are corroborated by experience, considerable advance has been made in the therapy of heart disease.

It can be used wherever digitalis is indicated. Per os it acts much more quickly than the powder, hypodermically in a few hours, intravenously, at once. It is not cumulative and its effects are not as lasting as that obtained from the powder. But the effect once reached can be maintained by the powder, in small doses.

## DEPARTMENT OF SURGERY.

EDITED BY ANDREW STEWART LOBINGIER, M.D.

### INTRACRANIAL SURGERY IN THE NEWBORN.

Dr. Harvey Cushing in the October *American Journal of Medical Sciences* contributes a characteristically original study of this subject and shows that preconceived ideas concerning the hopelessness of cerebral palsies in children are erroneous and that much promise

lies in prompt surgical interference in these cases.

The contribution is an amplification of deductions previously made and published and is supported by the extended report of four cases recently studied and operated. The author alludes to the contributions to this subject by Little about the middle of the last century

and to the careful pathological analysis by Sarah J. McNutt published twenty-five years later.

One is impressed in this analysis by the singular tardiness of neurologists in recognizing the traumatic features of palsies in the newborn.

The work of McNutt and Welch gave considerable impetus to these studies but the profession has been slow to accept these cases as distinctly surgical. The despair of Freund is quoted and Cushing shows plainly how hopeless are these cases when allowed to go without surgical relief. The clot becomes organized, cicatrices or adhesions form and the patient passes to a state of spastic hemiplegia, or of epileptic seizures.

The areas of sclerotic atrophy seen in these cases give rise to convulsions and seizures so typically Jacksonian in character that the picture is unmistakable. It is in the critical analysis and operation of recent cases that the author has illumined the pathology and given another illustration of his brilliant work. Long before this report appeared in print the fame of his splendid case in Cleveland had gone abroad and he adds here another equally gratifying. The two fatalities are so instructive, that, presented as they are in this report, their value is immeasurably enhanced in the frank portrayal of the features to be avoided in future cases possessing like characteristics.

The areas of sclerotic atrophy seen conditions at accouchment which contribute to these grave traumatisms. He doubtless considers the fact of their existence sufficiently graphic—not to say tragic—to point a cogent lesson against hasty and unskillful use of forceps. "It seems needful to add" he says, "anything to the story which these cases tell. We have learned several things worthy of mention. One of them is of a newborn child, which with proper regard for hemostasis and careful avoidance of exposure will stand a cranial

operation well. This is contrary, however, to the statements in our textbooks; but when one considers what an amount of traumatism every child must have to endure while making its entrance into the world it would seem reasonable to expect that a careful operation, provided there is no loss of blood, would be no more serious." He shows that the coagulation time in these infants is scarcely different from the adult. He concludes "If it can be demonstrated that a craniotomy on the newborn child, when conducted with due precaution and delicacy of manipulation is comparatively free from danger—and cases 1 and 2 show how well such operations may be tolerated—I believe the immediate risk of death and the sorry late consequences of meningeal birth-hemorrhages may be avoided in many cases by surgical interference. It is reasonable also to suppose that these explorations will at the same time lead us to a better understanding of the varying pathological features of this group of diseases in their early stages."

SUTURE OF THE SPINAL CORD.—George Ryerson Fowler in the October *Annals* discusses this subject and reports a case—being a contribution presented at the July meeting of the American Surgical Association. The case reported was a patient of 18 years shot in the column from the back on a level with the tenth and eleventh dorsal spines. The shot was a .38 calibre bullet fired at a distance of about thirty feet. Paraplegia resulted extending to an inch above the iliac crests. The bladder and rectum were paralyzed. Operation consisted of laminectomy in the tenth, eleventh and twelfth vertebrae. The bullet was found lying transversely between the severed ends of the cord. The ends of the cord were sutured with fine chromic gut, the dura included. (The author failed to state whether the ragged ends of the cord were cut away leaving smooth ends to



be coapted). The dura was further sutured independently with fine chromic gut. A temporary drain of strips of oiled silk was carefully placed and the skin closed about them. The wound healed kindly. A careful neurologic report is appended. The author refers to the Stewart-Harte case reported at the Albany meeting in 1902 and to the opinion prevalent prior to this case, that regeneration of the cord in man did not occur after being severed. "In comparing the result in the case reported by Dr. Stewart, with the conditions herewith reported the following points are worthy of note: Sixteen months after the injury, in Dr. Stewart's case, the patient was able to flex the toes, flex and extend the legs and thighs, and rotate the lower extremities. While in the sitting position she could raise the extended leg from the floor, and she was able to stand by supporting herself with her hands on the back of a chair. The bowels were under control except when diarrhoea was present, and moved every second day. The urine passed voluntarily amounted to about sixteen ounces in twenty-four hours; incontinence occurred during sleep. She had the sensations of touch, temperature, pain and locality; the difference between heat and cold, however, was not always distinguished. Rigidity of the muscles was present in a moderate degree; both ankle clonus and patellar clonus were present on each side. Reaction of degeneration absent. No bed-sores had ever developed, and the skin and nails showed no trophic changes.

In the case herewith reported, the following is to be noted in comparison: Twenty-six months after the injury voluntary motion is practically lost in the affected area. He is able to stand when supporting himself by the hands resting upon an apparatus, and to make some locomotion by swinging movements in a special frame on wheels. The bladder and rectal control is doubt-

ful, to say the least, the former acting automatically. He has the sensation that the bladder and rectum are about to empty themselves, and if the urinal or bedpan is brought to him promptly soiling is prevented. The amount of urine passed in this manner would probably average more than a pint in the twenty-four hours. Urine is sometimes voided during sleep. Sensation is practically abolished in the entire affected region, with the exception of an area about five inches in length extending down the outer side of the right thigh, where some sensation is present. He is not able to correctly distinguish between heat and cold. Tactile sensations are recognized, but are usually referred to a point two or three inches distant from the point touched. Marked rigidity and spasticity of both legs are present. Patellar reflex exaggerated; Achilles reflex marked. Ankle clonus present on one side and absent on the other. The reaction of degeneration is absent."

The Stewart-Harte case was operated on three hours after the injury, while in the present case upward of ten days had elapsed before consent to interfere operatively was obtained. The prolonged separation of the divided end of the cord and the presence of the foreign body had, in all probability, an influence in preventing a complete regeneration of the cord.

#### CORN REMOVER.

Salicylic Acid .....	10 grains.
Lactic Acid .....	10 drops.
Ext. Cannabis Ind. ....	5 grains.
Collodion .....	2 drams.

#### LIFE'S COMPASS.

Four things a man must learn to do  
 If he would make his record true;  
 To think without confusion clearly,  
 To love his fellow-men sincerely;  
 To act from honest motives purely;  
 To trust in God and Heaven securely.

HENRY VAN DYKE.

# SOUTHERN CALIFORNIA PRACTITIONER'S NURSE DIRECTORY.

NAME.	QUALIFICATION.	STREET.	TEL.
ALBERTS, MISS R. C.	Graduate Nurse	Fullerton	Long Distance
BARBOR, MISS E.	Graduate California Hospital	1035 S. Figueroa	Home 4804, Sunset M. 1400
BEVANS, MRS. ROSE A.	Graduate California Hospital	Hotel Minnewaska, 2nd and Grand	Main 2816; Home 6701
BOYER, MISS SARA	Graduate Nurse California Hospital	1006 W. 8th	Jefferson 6391
CAMERON, MISS KATHERINE	Graduate Grace Hospital, Detroit	395 Grand Ave., Pasadena	Black 471
CARDONA, MISS L. M.	Graduate Sisters' Hospital, L. A.	740½ S. Figueroa	Home 7337
CASE, MISS L. E.	Children's Hospital, San Francisco	542 Westlake Ave.	Jefferson 6303
CASEY, MISS MAE V.	Graduate California Hospital	719 Hope St.	Red 239
CAYWOOD, MISS J. EVELENA	Graduate California Hospital	La Park	Suburban 64
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COOPER, MISS JESSIE	Graduate Fabiola Hospital, Oakland	2321 S. Flower	Home 5344
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FERN, MISS DORA	Graduate California Hospital	1035 S. Figueroa	Home 4804, Sunset M. 1400
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HARDISON, MISS CLAIRE L.	Graduate California Hospital	1340 S. Flower St.	Home 7621
HARDISON, MISS JUNE	Graduate California Hospital	1340 S. Flower St.	Home 7621
HOAGLAND, MISS M. J.	Graduate Bellevue Training School, N. Y.	312 W. 7th	Main 793
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KERNAGHAN, MISS	Graduate California Hospital	1035 S. Figueroa	Home 4804, Main 1400
MILLER, MISS FLORENCE	Graduate California Hospital	1145 S. Olive St.	West 307
McNEA, MISS E.	Graduate Nurse	744 S. Hope St.	Red 4856
McCLINTOCK, MISS CLARICE	Graduate California Hospital	1232 W. 9th St.	Black 511
MILLER, MISS SUE C.	Graduate California Hospital	679 W. 3rd St.	Home 23451
NAGEL, MISS A.	Graduate California Hospital	1035 S. Figueroa	Home 4804, Main 1400
ODEMAR, MISS A.	Grad. Emergency and Gen'l Hospital	1550 Tolerman St.	West 4435
OLSEN, MISS JOHANNA	Graduate Nurse	1207 W. 8th St.	Telephone 4685
READ, BEATRICE	Graduate Fabiola Hospital, Oakland	28 Temple	Red 46
RUSSELL, MISS M. B.	Graduate Nurse, Edinburgh, Scotland	845 South Hill	Home 6851
SAX, MISS	Graduate California Hospital	1035 S. Figueroa	Home 4804, Sunset M. 1400
SERGEANT, MISS	Graduate California Hospital	2808 S. Hope	White 576
TOLLAN, MISS H.	Graduate California Hospital	423 S. Broadway	Home 2506
TOWNE, MISS LILLIAN	Graduate California Hospital	1035 S. Figueroa	Home 4804, Sunset M. 1400
WHEELER, MISS FANNIE A.	Grad. Hosp. of Good Samaritan	212 South Reno St.	Main 1782, Home 4131
WEED, MISS E.	Graduate California Hospital	Calexico, Cal.	

# SOUTHERN CALIFORNIA PRACTITIONER

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

Address all communications and Manuscripts to

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## EDITORIAL.

### A SALUTATION FROM THE SOUTHERN CALIFORNIA PRACTITIONER ON THE ATTAINMENT OF ITS MAJORITY.

It is not only the pleasure of the SOUTHERN CALIFORNIA PRACTITIONER to present to its subscribers in this issue, the usual greetings of the Season, but it is its privilege, in virtue of the fact that it enters upon the twenty-first year of its existence, to make a formal bow to the professional world, and to renew at the same time its pledge to have the PRACTITIONER'S pages continue to stand for the best interests of the medical profession in the Great Southwest.

Twenty years ago, when the PRACTITIONER was founded by its present editor, "El Pueblo de Nuestra Senora Reina de Los Angeles"—"The Town of Our Lady, the Queen of the Angels"—had a population of little more than 15,000 souls and there was not a single

paved street within its confines, nor were sky-scraper structures even dreamed of.

To-day, by way of contrast, there is a municipality of more than 200,000 people, growing with tremendous strides and there are miles and miles of paved and graded streets, and handsome and ornate business and residence structures without end.

Commensurate with this material growth of the city, has been an increase in the number of medical practitioners, so that at the present time there are more than 750 legally licensed physicians in the county of Los Angeles, whose lives and work, are, however, cast along much easier lines and in a far less harsh environment, than that which met our professional brethren who were among the pioneers of a quarter and a half century ago.

It is not the purpose of these lines to



go into details concerning the work done by the PRACTITIONER during the last two decades. Suffice it to say, that founded at almost the same time with the College of Medicine of the University of Southern California, this publication has endeavored from its inception, to be a faithful exponent of the activity and work of the physicians of the Great Southwest, and its printed pages of a score of years not only present the only permanent historical record of the local medical profession during that time, but they also bear witness to its efforts to promote the scientific, social and material interests of our guild.

The PRACTITIONER thanks its friends for their cordial interest and co-operation in the past and hopes that its future course may be such as to continue to merit their good will and esteem.

On our twenty-first birthday and on the threshold of what we trust may prove even a better future than a very kind past, the PRACTITIONER salutes its friends and the world.

#### EDITORIAL CHANGES.

Our readers will notice the changes in the editorial staff of this magazine. Dr. George H. Kress who with this issue joins Dr. F. M. Pottenger as assistant editor received the degrees of B. S. and M. D. from the University of Cincinnati. During his student days he was editor of his college paper and since entering professional life his pen has not been idle. He has a love for the work that the readers of the SOUTHERN CALIFORNIA PRACTITIONER will soon realize.

Dr. W. Jarvis Barlow now becomes one of the associate editors. Several of the best editorials that have appeared in the SOUTHERN CALIFORNIA PRACTITIONER during the past year were written by Doctor Barlow and we are glad to have him regularly associated with us in this work. Drs. W. A. Edwards, F. M. Pottenger, Andrew Stewart Lobinger and Dudley Fulton will continue their departmental work. There is not a medical journal in America but would be glad to have their contributions.

Our aim, our earnest aim, is to have in the SOUTHERN CALIFORNIA PRACTITIONER a medical journal that will command the respect of the profession of the Pacific Southwest and with these able collaborators the outlook is certainly hopeful.

#### BERI-BERI.

With the increased responsibilities of the United States in the Eastern countries, the Philippine Islands, etc., and the greater communication of our people with China and Japan, it is of interest and importance that the life and customs of the people in these countries be made known to us.

Here, on the Pacific Coast, this knowledge will soon be essential, and in the development, the physicians must be alive to play their part and be prepared to recognize among these foreign people the diseases which in the past have been more or less strange to us. I refer here especially to that disease known to the yellow race as "Kak Ke" (diseased leg) or "Beriberi" (debility). This is possibly the oldest disease in medical literature, certainly described

by the Japanese 2,500 years ago. Its exact etiology is as yet unknown, and sporadic cases occurring in our communities give sufficient reason to arrest our attention. Furthermore, a case of Beriberi has recently appeared in the fever ward of the Los Angeles County Hospital, having been admitted on account of the continuous temperature, of which case I will speak later.

The disease is generously and generally found in tropical climates. Those countries especially of interest to us, on account of the increasing communication, are China, Japan, the Philippine Islands, and Central America. The diagnosis is easily and early made in these countries as the disease occurs in epidemic and endemic forms, but is difficult in isolated cases, which may occur in any place. Although the etiology is not definitely settled the disease to all appearances is an infectious one—an infectious neuritis caused by a micro-organism or organisms, whose morphological character is not yet demonstrated. Many observers have described different forms, and hold as many views. Others find various bacteria in the blood postmortem, so we know the specific germ is yet undemonstrated. The best Japanese authorities to which I have had access, claim the poison is introduced with food—rice or flour—and the toxine is produced in the stomach and intestines (always the food most blamed is rice), or that some chemical change has taken place in stale or poorly stored rice. The cause advanced by Manson, and recently published by Cohen of Baltimore is that "Beriberi is due to a germ which resides in the soil or in the houses and

surroundings of beriberi places, that it there distils a poison which on being absorbed produces a neuritis." In support of this change of location, hygiene, treatment, etc., cured the cases, but along with this treatment the diet was changed. It would seem that some credit should be given to the diet, as the Japanese would claim, that is, the staple article rice was stopped and nitrogenous foods added. The mortality from Beriberi in India is from 14 to 30 per cent. In the Japanese army in 1875 it was 17 per cent. Two years later it ran to 30 per cent. In recent years the diet of the Japanese soldiers has been changed to more varied articles with the addition of albuminous food and the epidemic among soldiers and sailors has ceased, as illustrated in the late Russo-Japanese war. The credit of this change it is stated, is due to Dr. Takagi.

It seems only necessary to remember the two distinct classes in which this disease appears, the "wet" and "dry," or the "oedema" and "atrophy." Either or both of these may be found in varying degree, so that other classes are sometimes made, such as the "incomplete," the "mixed." After all, each case shows more or less of each of these classes. Cohen, who has had service in the Philippine Islands, divides each case into three periods—stage of oedema, stage of paralysis, stage of convalescence, or death. He has found that every case earlier or later, develops some oedema and that the greater the degree of paralysis and atrophy, the less oedema. The principle symptoms are, oedema, pain, atrophy, and impaired locomotion. In the atrophic form pains

and weakness appear in the limbs, followed by loss of power. The atrophy is soon marked with disturbances of sensation, which may extend to the muscles of the face. This form resembles very much the peripheral neuritis caused by arsenic and alcohol.

The wet form shows marked oedema from the start, which extends over the subcutaneous tissue, and there may be affections in any of the serous cavities. Fever in any of the epidemics has been very rare. Cases have been reported with slight fever.

The treatment by drugs has been entirely unsatisfactory, but most gratifying with other methods, namely through diet, hygiene, and removal from infected places. Cohen recommends the greatest possible amount of sunlight and fresh air as effecting a cure. He exposes the bodies directly to the sun's rays, stops rice, and gives bread, beans, fish and meat, taking eight weeks to three months for a cure.

Now, in regard to the case appearing at the County Hospital; a Japanese farmer, age 27. Among five brothers one suffered from several attacks of beriberi. The patient came to this country last May, and had never been in circumstances to get good food. In September he began having oedema in the legs and weakness of the muscles of the arms. In a few days he noticed numbness in his legs with some pain. After three or four weeks he had a chill, following which afternoon fever, when he was admitted to the hospital. The symptoms (except the fever) were those of beriberi, but after one week "rose" spots appeared, the spleen enlarged and felt, the Widal reaction was

positive, so that during the second week the case, without the history, would seem one of typhoid complicated by peripheral neuritis. The typhoid attack proved a mild but typical one and the other symptoms grew worse during the first two weeks, then somewhat diminished. From the history of the patient and the subsequent symptoms, this was undoubtedly a case of beriberi in the beginning, with typhoid fever in addition.

W. J. B.

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#### THE NEW OFFICERS OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.

The annual meeting of the Los Angeles County Medical Association, held on December 15th, 1905, resulted in the election of Dr. F. C. E. Mattison of Pasadena as President, Dr. Raymond G. Taylor as Secretary and Doctors Stanley Black, George L. Cole and Claire Murphy as members of the Council.

The reports of Secretary Raymond G. Taylor and Treasurer John C. Ferbert showed an increase in the average attendance of about twenty-five and a fair balance in the treasury.

The proposed amendments whereby two dollars of each member's dues will hereafter be used for the local needs of the Association instead of only fifty cents, became laws, so that it will be possible for the Association to engage in certain local activities which up to this time, have been out of the question, owing to a depleted treasury.

The Council has already inaugurated a decided change from the previous order of things, in deciding to have week-



ly instead of bi-monthly meetings of the Association.

While the bulk of the labor of this plan will fall upon the President and Secretary of the Association, since those gentlemen must work up the programmes, the final success or failure of such meetings must come back to the members as a whole, since their attendance or non-attendance will determine whether the weekly meetings can be successfully and continuously carried on.

No mention is made of the papers read by the essayists since these have generally been creditable to the Association. The officers also may be depended upon to get up interesting programmes. But on the point of attendance of the average members there is grave reason for doubt, and it is to these latter gentlemen, that the PRACTITIONER would address the plea, that they do their part in helping President Mattison and the other officers of the Association make the County Medical Association weekly meetings a credit to all concerned.

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#### **PATENT MEDICINES AND THE UNITED STATES INTERNAL REVENUE DEPARTMENT.**

On November 25, 1905, the Commissioner of Internal Revenue, acting under the ruling of September 12, 1905, that certain patent medicines containing excessive amounts of alcohol, should be classed as alcoholics, and their wholesale and retail venders required to pay special taxes thereon, declared that the Department had carefully analyzed a number of such patent medicines and

had placed under the ban of the law the following:

Atwood's La Grippe Specific.

Cuban Gingeric.

De Witt's Stomach Bitters.

Dr. Bouvier's Buchu Gin.

Rockandy Cough Cure.

Duffy's Malt Whiskey.

Gilbert's Rejuvenating Iron and Herb Juice.

Hostetter's Stomach Bitters.

Kudros.

Peruna.

Dr. Fowler's Meat and Malt.

The order went into effect against the manufacturers of these remedies on January 1, 1906, and will go into effect against retail merchants of the same on April 1, 1906, these time extensions having been granted to allow those who purchased these remedies in quantities and in good faith, to dispose of them.

The Department has under consideration a large number of other remedies but owing to the great care necessary in the making of analyses, it is able only to pass judgment upon them in small groups.

This work of the Internal Revenue Department is certainly a most praiseworthy undertaking and one which of necessity must help both the lay and professional worlds, and should have the full support of all medical practitioners.

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#### **SOME PIONEER LOS ANGELES PHYSICIANS.**

On another page of this issue of the PRACTITIONER is printed a paper read by Mr. Henry Dwight Barrows before the Historical Society of Southern California, in which he gives some re-

miniscences concerning several pioneer physicians of our city. Mr. Barrows came across the Isthmus of Panama in 1852 and has resided in Los Angeles since 1854.

A fee table of the time is appended to Mr. Barrow's article and should be of interest to modern day practitioners, even though these latter do not charge "five dollars for each bleeding."

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**IN MEMORIAM.—DR. MAYNARD.**

At a recent meeting of the Los Angeles County Medical Association the following resolutions were unanimously adopted:

Whereas our dear friend and fellow practitioner, Henry H. Maynard, M.D., after a long and painful illness, was released from his suffering at 5:30 p.m., November 3, 1905; therefore be it resolved that:

We, the members of the Los Angeles County Medical Association, shall ever cherish the memory of the high character, the unselfish life, and the superior professional judgment and skill of our deceased brother, and

Resolved that:

We extend to the wife, daughter and sons our deep sympathy with them in their loss of one whom we all know was an ideal husband and father.

Resolved that:

These resolutions be spread upon the minutes and an engrossed copy signed by the Committee and our President and Secretary be sent to the family.

E. R. SMITH,

W. W. BECKETT,

L. S. THORPE,

Committee.

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**THE MEDICAL CORPS OF THE UNITED STATES ARMY.**

The United States *Congressional Record* of December 7th, contained on page 210 the following item: "A letter from the Secretary of War was read, transmitting a draft of a bill to increase the efficiency of the Medical Department of the Army—and was referred to the Committee on Military Affairs and ordered to be printed."

THE PRACTITIONER would call attention to the fact, that this bill, while intended to raise the status of the medical corps of the United States Army, is of such great importance from the standpoint of preventive medicine, that it should receive the prompt attention and aid of the profession in civil life throughout our land, and this all the more, because army officers are not allowed to lobby for measures affecting themselves.

The Medical Corps of the United States Army at the present time is not only unduly restricted in numbers—the line officers are commissioned for an army of 100,000 strength while the medical officers are proportioned to an army of only 60,000 men—but its members are denied the privileges and authority which their education, training, calling and the needs of the army and humanity should give them.

Thus, while medical officers are largely held responsible for preventable diseases in camp, a line officer in the United States Army is under no obligation to accept a medical officer's recommendation as to the site or sanitation of a camp, and medical officers have no ready means of going over the

head of a line officer, even though the surgeons are convinced that the line officers are unnecessarily endangering the health and lives of their men.

Recently, Major L. L. Seaman of New York, in a most masterly address delivered before the Association of Military Surgeons of the United States, made some telling comparisons between our high morbidity and mortality rates from disease and wounds in the Spanish-American war and the Russo-Japanese war. As was well said by him, the most important lines along which the Japanese excelled in their late war, was in the Medical, the Commissariat and Transport Departments, that is, in the *life saving* and *life-preserving* departments, and yet the United States, in sending its five military attaches to the Japanese Army for the purposes of observation, sent not a single representative from any of these three departments, showing how thoroughly the line dominates affairs in our army.

Our medical brethren in the Medical Corps of the U.S. A. are not in a favorable position to work for the bill referred to, and which has been recommended by both President Roosevelt and Secretary Taft, but no such restrictions hold as regards the medical profession in civil life, which should, throughout the land, inform its Congressional representatives, to give to Secretary Taft's bill their careful consideration and aid.

For our own section of the country, the county societies of the Southwest should make it their business to acquaint their Congressmen with their wishes in this respect and the Council

of the Los Angeles County Medical Association, might well take the initiative by passing a resolution urging Senator Flint and Congressman McLachlan to give the Taft bill their support.

There is a group of politicians in the House, who have for years, persistently worked against the best interests of the Army Medical Corps and unless the medical profession in civil life through its Congressmen, takes a hand in this matter, Secretary Taft's bill will probably not be passed.

The subject is an important one, and one in which every citizen, through a letter to his Congressman and Senator, may be of aid. No one should be remiss in so simple, and yet so important a duty.

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#### EDITORIAL NOTES.

One firm in New York recently received a shipment of 25,000 leeches.

Dr. A. F. Wagner has located in Alhambra, Los Angeles county.

Orange County, Cal., is agitating the necessity of a county hospital.

Dr. J. L. Ballou, formerly of North Carolina, has located in Aztec, N. M.

Dr. West Hughes has been spending two or three weeks at Arrowhead Hot Springs.

Dr. A. D. Bowman, formerly of Lewiston, Maine, has located in Long Beach, Cal.

Dr. A. M. Tuthill of Morenci, Arizona, so well known in Los Angeles, has been on a hunting trip in Old Mexico.

Dr. S. J. Gardner, surgeon of the S. P. Hospital, San Francisco, has been visiting in Los Angeles.

Dr. B. E. Sibley of Rialto, San Bernardino county, has been appointed house surgeon of the Massachusetts General Hospital at Boston.



Dr. J. W. Jauch was recently the victim of a holdup in Los Angeles. He lost his watch and chain, a diamond pin and about \$33.

Two new physicians have recently located in San Jacinto. One for humans, the other for horses.—*San Jacinto, (Cal.) Register*.

Dr. F. M. Pottenger delivered an address on "Early Diagnosis" at the annual meeting of the Riverside County Medical Association on January 8th, 1906.

Dr. and Mrs. C. VanZwalenburg recently entertained the Riverside County Medical Society with an elegant supper which followed the monthly meeting of the association.

The semi-monthly meeting of the Santa Barbara County Medical Society was held at the office of Drs. Bates & Shelton, Dec. 6th. The paper of the evening was by Dr. George Brown, and the subject "Typhoid Fever."

The Ventura County Medical Society recently elected officers as follows: Dr. T. E. Cunnane, president; Dr. A. A. Maulhardt, vice-president; Dr. C. Teubner, secretary and treasurer. Dr. R. D. Potts of Oxnard was unanimously elected a member of the society.

Quite a number of the Los Angeles and Pasadena physicians confess to be devotees of the scientific prize ring. Dr. Stanley P. Black in an address before the medical society at Pasadena acknowledged that he would much rather see a prize fight than a football game.

The Yavapai County Medical Association held its annual meeting in Prescott, Arizona, Dec. 10th. The following were elected as officers for the ensuing year. President, Dr. John W. Flinn; vice-president, Dr. Samuel V. Fitzsimmons; secretary and treasurer, Dr. Clarence E. Yount.

Dr. Chas. Frederick Taggart, the Los Angeles surgeon, was born in Chester, Ill., forty-four years ago. He received

the degree of doctor of medicine from the University of Missouri, and came to Southern California in 1886. In 1883 Dr. Taggart did post-graduate work in Europe.

The elegant home of the "Alkaloidal Clinic" was recently burned, and the name of the journal has been changed to "The American Journal of Clinical Medicine." Dr. W. C. Abbott and Dr. W. F. Waugh still continue in editorial charge and have added to their staff Dr. Emory Lanphear and several other well known men.

Dr. Vincent Y. Bowditch of Boston, who is well known in Los Angeles, was recently unceremoniously dismissed from the position of visiting physician to the State Sanatorium for consumptives at Rutland, Mass., which he has held with honor for many years. A disagreement in the board of trustees was the cause of the trouble.

Dr. F. M. Pottenger entertained the officers and Board of Directors of the Southern California Anti-Tuberculosis League at dinner at the Angelus Hotel on Tuesday evening, December 12th. Those present were Dr. Geo. E. Abbott, Dr. H.G. Brainerd, Dr. Chas. C. Brown, Dr. Rose T. Bullard, Dr. B. F. Church, J. H. Francis, Dr. W. W. Hitchcock, Dr. R. W. Miller, Dr. L. M. Powers, Dr. W. LeMoyne Wills, Dr. Frank D. Bullard, Dr. F. C. E. Mattison, and Frank M. Coulter. A very enjoyable evening was spent and the work of the League for the coming year was considered and outlined.

We have received three monographs upon the subject of tuberculosis by Dr. S. A. Knopf, of New York City, that we consider make a valuable addition to the literature of this important subject. The following are the titles of these three papers: "The Sanatorium for Tuberculous Patients and its Medical and Social Mission;" "The Tuberculosis Situation in Penal Institutions, with Especial Reference to the State

Prisons' at Sing Sing, N. Y., and Columbus, Ohio;" "The Treatment and Care of Advanced Cases of Pulmonary Tuberculosis." We believe that any physician who is interested can probably get a copy of each of them by addressing the author at 16 West 95th street, New York City.

The following members were present at the meeting of the New Mexico Board of Health in Albuquerque, December 6th and 7th: Dr. G. W. Harrison, president, Albuquerque; Dr. T. B. Hart, vice-president, Raton; Dr. William D. Radcliffe, treasurer, Belen; Dr. B. D. Black, secretary, Las Vegas. These applicants were granted licenses to practice medicine in New Mexico: Dr. B. F. Herring, of Lake Arthur; Dr. J. R. C. Lynn, of Roswell; Dr. Isabel D. Lane, of Clayton; Dr. Jay D. Nusbaum, of Albuquerque; Dr. T. H. Dabney, of Albuquerque; Dr. J. L. Ballou, of Aztec; Dr. Margaret A. Fleming, of Belen; Dr. Clifford S. Losey, of Las Vegas; Dr. Homer Frank Parr, of Carlsbad; Dr. L. A. Brice of Carlsbad; Dr. Frederick H. Lay, of Raton; Dr. Charles H. Kiehl, of Albuquerque; Dr. J. G. Holmes, of Fierro; Dr. Joseph R. Bryan, of Portales; Dr. Zachary T. Martin, of Carlsbad; Dr. A. L. Breeding, of Texico; Dr. George N. Fleming, of Raton; Dr. G. R. Rucker, of Roswell; Dr. J. Y. Lapsley, of Dawson; Dr. E. D. Strong, of Silver City; Dr. G. K. Angle, of Silver City; Dr. H. D. Nichols, of Tularosa; Dr. Frank E. Mera, of Santa Fe; Dr. R. B. Raschbaum, of Roswell; Dr. Elda S. Dunn, of Albuquerque—twenty-five in all. The following health officers were appointed to fill vacancies: Dr. J. M. Shields, of Perea, appointed for Sandoval County; Dr. William H. Burr, of Gallup appointed for McKinley County, and Dr. William MacLake of Silver City, appointed for Grant County.

For the benefit of the uninitiated, we will state that the following item ap-

peared in *L'Avenir Du Sud De La Californie*, in its issue of Samedi, 16 Decembre, 1905, and refers to Dr. B. Sassella, who has just recovered from a serious illness. As will be noted from the list of guests, quite a number of our local colleagues took part in the evening's entertainment.

The item is as follows:

"Le retour à la santé de notre excellent ami, le Dr. B. Sassella l'un des médecins de l'hôpital français, fut célébré d'une façon charmante par plus de 30 convives en un banquet donné au restaurant Campi dimanche soir dernier. Les invités étaient pour la plupart des confrères du docteur. Au dessert, M. Sassella, dans une improvisation très heureuse, remercia les invités de la sympathie qu'ils lui témoignèrent en répondant tous à l'invitation qui leur avait été faite. Les docteurs Cole, Lindley, Brainerd, Kurtz et Lemoyne-Wills répondirent affectueusement à son toast et furent unanimes à reconnaître la valeur et l'extrême honnêteté de ce praticien expérimenté. Le major di Rudio, assis à la droite du docteur et l'avocat Earl Rogers, qui était à sa gauche, prirent également la parole et rendirent hommage aux qualités de leur ami. Remarqué parmi les invités: MM. le major di Rudio, les docteurs Lasher, Brainerd, Utley, Moore, Ellis, Barber, Rogers, Cole, Smith, Myers, Lindley, Kurtz, Babcock, Lemoyne-Wills, Powers, Bullard, Hagadorn, Roth et Leaman. MM. Rogers, Violé, Orsatti et Mars."

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"I held it truth, with him who sings  
To one clear harp in divers tones,  
That men may rise on stepping stones  
Of their dead selves to higher things."

## MISCELLANEOUS.

### THE SALTON SEA.

The *Indiana Medical Journal* for December, 1905 contained the following item:

"Dr. Ross Moore, class of 1900 in Indiana Medical College and also of Western Reserve Medical College, now located at Los Angeles with Dr. H. G. Brainerd in the practice of nervous diseases, was in the city Nov. 20-21, after a two months' course of study at Johns Hopkins, Pennsylvania Medical and Ann Arbor. He was formerly a student of the late Dr. Joseph Marsee when in Indianapolis. Dr. Moore gave the *Journal* the accompanying note from observation as to "Salton Sink," California's new inland sea:

"In the middle of that portion of the American desert which lies between the Colorado river and the coast range is a place known as the Salton Sink. It is below sea level, but was cut off from the Gulf of Lower California at some prehistoric time, and with one exception has been a dry alkali plain since the knowledge of man. South of this sink lies the Imperial country, which has lately been reclaimed by irrigation with water brought from the Colorado river through a canal. This canal was dug some years ago when the water was low. Last year the water rose to such a height that it could not be controlled, and it cut a new channel, following the line of the canal. To-day the Colorado river runs into the Salton Sink instead of into the Gulf of Lower California.

"The water in the sink has been rising at the rate of an inch a day for the last 270 days, and where there was a desert there is now an inland sea eighty miles long and thirty miles wide. The beds of salt and alkali have made this water about an 8 per cent. solution, but as water is added it will become more nearly fresh.

"The main line of the Southern Pacific railroad runs through this sink and is at one place about 267 feet below sea level; this is at a station known as Salton. This new sea has encroached upon the tracks and has finally driven them back. The company had a tremendous task to keep the main line open around the edge of the water. All efforts to change the Colorado back into the old channel have failed, and it seems as if the whole country will be flooded. If this occurs, California will have about four hundred square miles less of desert to reclaim, and will possess a vast new inland sea."

### CHRISTIAN SCIENCE AS SEEN BY AN ENGLISH BISHOP.

Christian Science which a dozen years ago was an unknown thing in England, has now some fifteen churches dedicated to the cult of Mother Eddy. Three of these are in London, and the members are said to number a thousand, without reckoning several thousand "adherents" who like the Peri stand at the gate of Paradise without entering. Among the devotees are several people who in point of intellectual culture are considerably above the average. One of the most notable is Mrs. Butter, the wife of the Master of Trinity College, Cambridge. She was a Miss Ramsay and gained great academic fame by taking the first place in the classical Tripos—which is considered here a very remarkable achievement—some years ago. Her triumph was the more noteworthy inasmuch as she had not begun the study of Greek till she was seventeen. Within the Church of England itself there is a section, including a number of clergymen, who while not formally subscribing to the teachings of Mrs. Eddy, hold that the principle on which her doctrine is based is true. In their opinion it represents a power lost to the church,



and they are working towards the recovery of that power by doing their utmost to spread belief in faith healing. This fact supplies the interpretation of a recent deliverance by the Bishop of London on Christian Science. Addressing a meeting of the Women's London Diocesan Association on November 11th he endeavored to make his audience realize the longing of the sick for visits which opened a way for possibly healing effects. In every one, he said, there was a personality which in time of sickness might be strengthened to bear, and even to triumph over pain. In illustration of this statement, the Bishop related an incident which had come under his notice. The wife of one of his clergymen was recently faced with the appalling prospect of having within two days to undergo an operation which might cost her her life. When he (the Bishop) called upon her, he found her in a state of moral collapse; partly owing to fear and partly to other causes, her faith and hope were entirely gone, and the physicians and surgeons recognized that it would be impossible for the operation to be performed while she was in that state. He would pass over the sacred half-hour that he spent with her, but it was a fact that two days later she walked from her room to the operating table without a quiver. The surgeons exclaimed: "What has the Bishop of London done to you?" She replied in simple, straightforward words: "Something which none of you could have done." To her inmost being, where the faith and the hope and the courage had died down and crumbled, with God's help alone he had brought to her that reinvigoration of her central being which she needed, and the effect of bringing the power of God to her central being brought back again her faith, her hope and her courage, and she became again a Christian woman who could look death and trial in the face. In many instances, when one invigorated the faith, the hope and the

courage of a sufferer, one thereby wrought a great effect on the bodily condition of the patient. These he believed to be absolutely true, and he believed they lay at the basis of the success—so far as it went—and the prevalence of Christian Science; but when one went on to other points on Christian Science one was erecting a real truth—he said it deliberately—into a gigantic heresy. We had to learn from heresies to-day as we had learned from them in times past; there was not one single heresy that had ever existed that was not recalling the church to some forgotten truth; and every heresy lived upon the element of truth which it contained. What he wished to say to them as church workers was, "Keep the truth." The clergy ought to approach the bedsides of the sick with far more faith; they ought to pray for the recovery and lay hands on them with far more expectancy that they would recover; in doing their sick visiting they ought to look with far more hope for the recovery of the patients and not look alone to the preparation of the soul for death. The Bishop said he knew that there were present one or two who thought they had special gifts of healing. As their Bishop he put it to them that they must never try to exercise those gifts apart from the medical profession. It would be observed in the little story he has told that he never suggested that the woman should not undergo the operation which was so essential to her cure. He wished the medical profession to understand that the church regarded their healing art as a sacred thing. When he was ill he felt that the doctor who came to him was as much sent by Jesus Christ as the clergyman who called to visit him. As Christian ministers they ought to ask for and demand a right to have their place in the sick room allotted to them by doctors. Of course, they must exercise tact and discretion, but it would be an ill-return for the honor

the clergy were seeking to give the healing art if they were to be excluded from the sick rooms of either the wealthy or the poor. As might have been expected, on the strength of this utterance, the Bishop is claimed by the Christian Scientists to be one of themselves. If, they say, he had adopted the advice which he gave to pray for the recovery of the sick, he would have found, as they claimed to have found in hundreds of cases, that no operation was necessary; that faith alone was sufficient. This is an example of the evolution of dogma of which theologians speak, for in the book which is the Holy Writ of the Sect, the prophetess expressly excludes surgery from the scope of her treatment.—*Medical News*.

#### DR. J. M. T. ALLAN IN MEXICO.

The following from the *Los Angeles Daily Times* of Dec. 17th, will be very interesting reading to many of the friends of Dr. Allan, who has now located at 1804 South Hope street, Los Angeles.

"Dr. J. M. T. Allan has just returned from a fourteen months' residence in Chinipas, a little mountain town, 250 miles from Chihuahua, Mex., where he was surgeon for the Palmarejo and Mexican Goldfields Company, an English syndicate engaged in developing the mines of that part of Mexico. Dr. Allan was formerly resident physician at the California Hospital and went to Mexico, accompanied by his bride more than a year ago. His practice included that of the natives for miles around Chinipas and his account of the country and its customs is most entertaining.

"There are two ways of reaching the town of Chinipas," says Dr. Allan, "one is to go by the way of Nogales to Guaymas, thence to Alamos, passing through the Yaqui country inhabited by the Yaqui Indians. At the time my wife and I made the trip the rivers were

high and impassable by this route, so we went to Chihuahua by way of El Paso on the Mexican Central road and from there down to Miñaca and traveled the balance of the way in the saddle—a distance of 250 miles."

#### ALONG THE CAMINO REAL.

"A part of the trail," continued Dr. Allan, "lies over the old Camino Real, running from Chihuahua to Alamos. In places it is just about as wide as a mule's foot and worn four to six inches deep in the solid rock. It is one of the most beautiful roads in Mexico and people who have visited the Grand Cañon tell me that some of the views along the old Camino Real in Mexico are even more marvelous and picturesque. The road between Bocoyna and Cuiteco passes along the brink of the wonderful Barenea de Cobre, a valley or basin so deep and of such precipitous walls that two days are required to make the descent. The balanced rocks and the old churches of Bocoyna and Guazapares are on this road and the railroad now in course of construction from Chihuahua to Topolobampo follows the course of the Camino Real for a portion of the way. Frequently one will be traveling along a barren stretch of country, over rocks and through sands, when suddenly the way opens out into a beautiful natural park with grand old trees overhanging the road, and you are liable to come across blanket-clad Indians, which blend harmoniously with the wild nature of the scene. Occasionally you pass the ruins of an old hacienda which was once, no doubt, the home of some wealthy Mexican. In some places the road is lined with fan palms, and as they do not grow wild in this section of the country, this indicates that they were planted along the Camino Real, probably brought there by the Indians under the direction of the padres.

#### THE PASSION PLAY.

"The priests do not have the profound influence over the people that

they once did in Mexico, and President Diaz is largely responsible for that. Whereas they were formerly allowed to hold their religious celebrations and festivals where they pleased, they are now restricted to the limits of the church grounds proper and are not permitted to parade all over the village. Last Easter we witnessed a very interesting ceremony which was a rude representation of the Passion Play. A great gathering of Indians and Mexicans assembled at Chinipas for the religious festival.

"In the rudest possible way the death, burial and resurrection of Jesus was represented. The bier, borne on the shoulders of stalwart Mexicans, was placed in a pagoda erected for the purpose within the churchyard. It was covered with a white linen cloth and decorated with flowers and tinsel. At the head of this sepulcher stood three figures representing Mary, the Mother of Jesus, Mary Magdalene and John the Baptist. The cross, made of heavy timbers, was carried on the shoulders of swarthy Mexicans, some of them old and wrinkled. The scene of that wierd procession, the women in their black rebosas, the devout Indians, the throngs of little Mexican children was impressive and picturesque beyond description.

#### PRIMITIVE CUSTOMS.

"In Chinipas, the most primitive customs prevail. The plowing is done with a forked stick drawn by oxen; the poorer class of natives live chiefly on maize, dried beef and beans; the women wash the clothes on stones and grind the corn for tortillas between rocks; the little boys smoke cigarettes from the time they can walk. The better class of houses are built in the form of hollow squares and the inner patios of those in which dwell the wealthy Mexicans are beautified with flowers and fountains. There are three schools in the village of Chinipas, which has a population of 1,000 or 1,200.

Only Mexican teachers are employed and only the Spanish language is spoken among the natives.

"In the larger towns and the cities of Mexico many American ideas are being adopted. Chihuahua claims the finest opera house this side of Chicago, and the street car service and style of architecture are largely American. The English language is now compulsory in the schools of the City of Mexico."

Dr. Allan has returned to Los Angeles to reside permanently.

#### THE COURTS OF SONORATOWN— THE HOUSING PROBLEM AS IT IS TO BE FOUND IN LOS ANGELES.

BY BESSIE B. STODDARD.

Secretary of the Playground Commission, and  
Member of the College Settlement, Los Angeles, Cal.

The thousands of tourists that visit Los Angeles each year leave the city with the refreshing idea that here at least is a center without its tenement problem. They have driven past miles of artistic houses set in lovely gardens, and the trolley has displayed to them countless other miles of neat cottages and homelike bungalows, each one surrounded with its due share of earth and flowers. They have noticed the many vacant lots giving breathing space within the city limits, and just beyond the limits the huge circumference of suburban sites so easily reached by modern electric lines. They have concluded that surely here is a city with room enough for all.

If these tourists journey through what is called Sonoratown (the section of the city that was the original Spanish pueblo) to see the few remaining old adobes, they notice merely the long rows of one-story adobe and frame buildings lining the rather quiet streets. Here and there if they have observed a narrow alleyway running back between two houses, or a double gateway with children flocking in and



out, they have not intruded, supposing that beyond lay the back gardens of the people who dwell in the rows along the street. But had they pushed into these private-looking little thoroughfares they would have been dumb-founded with what they saw, for in the "courts" beyond lies the "crowding" proposition, forcing itself in a new way upon a new city.

Swarming, tumble-down habitations of every variety are these nests of humanity, the courts of Sonoratown. Once these places were the courtyards of the adobes in front, and the "Californians," as the original Spanish settlers have always called themselves, had

plenty of room for gardening and back-yard work, and for the play of big families of children. Now the adobe in front has become a tenement for several families, and the courtyard has been honey-combed with shacks, and tents, and nondescript barn-tenements of one and two rooms (or perhaps two families may occupy one room), until one can think of nothing but the squalor of a Chinese city. You may walk in the middle of a "street" and touch two rows of houses facing each other, or follow a winding path between habitations, tripping over tubs and clothespoles and outdoor fire-places, over dogs and cats and children at play



and the tinier tots just creeping about.

Everywhere in the air rings the Spanish language—not a syllable of English is heard. The "maestras" and visiting nurse from the College Settlement must have some knowledge of the foreign tongue, for it is the only "open sesame" to these human hives. A courteous demeanor and a few words of the mother tongue will carry the stranger straight to the hearts of the people. If you are a novice, you are at first appalled by the physical conditions, and you think that the people must be as degraded as their surroundings are squalid. Presently your faith returns as you become more and more impressed with a great social offset everywhere present, namely, the kindness of the people. You notice that the children play happily together without quarreling, the elder ones looking out for the smaller; that the kitten, though mauled from affection, knows nothing of abuse; that father and mother treat each other and their children with consideration and respect. You discover that the hungry family is shared with, that the sick stranger is cared for and housed, and that one big

family occupying two tiny rooms not infrequently offers hospitality to another big family that cannot pay its rent-money. You may call at a "tent" made of bags and rags and tin cans besides the original canvas, and at the door (an ex-window screen, patched) be met by a kind-faced señora. You stoop and crowd in and are seated with solicitude for your comfort upon the only chair, a backless one, while your hostess takes the side of the bed. The children come trooping in to meet the visitor and gravely shake hands, the mother introducing each by name. Your Saxon bluntness is overawed by the polite phrases that come so naturally from the lips and heart of your hostess, and you may easily feel awkward at your own lack of simple elegance. You scarcely can notice the meagreness of this poor little home, so impressed are you with the friendliness expressed in so courtly a manner. Nor by any means is dirt universal in these poor little domiciles and you may carry away with you wonderment at the order and cleanliness as well as at the etiquette of the place.

The inhabitants of the courts are not the "Californians" as might be sup-



posed, but newcomers from Northern Mexico. The "Californians" for the most part are gradually drifting away from the old pueblo to other parts of the city. They do not fancy this in-pouring horde of so-called "peons," who are of lower caste. The remnant that is there occupies the better houses facing the streets and does not mingle socially with the life of the courts. And yet just a few years ago the Settlement knew Sonoratown as the poor but proud old California pueblo full of the life and gaiety of the people of the soil, a veritable community in itself.

But the disappearance of the original inhabitants is not alone due to the filling up of the patios by the landlords with these miserable nondescript tenements. A second and as valid reason is the incoming of the Italian element. The "Californians" had lost their property and become renters. The Italians came with their ability to save and to buy, and have inherited the greater part of the land. Everywhere, where the courts are not, are the homes of the new immigration—their shops and their hotels. The homes are cottages, and fairly comfortable, and almost always are to be seen the humanizing little vegetable patches. But already the owners are discovering the value of rear tenements and cheap lodgings are erected for the use of the many young Italian bachelors, and for the Slavonian young men just recently beginning to arrive in the community.

But to go back to the courts. The railroads have needed gangs of men in their construction of new lines and have gone down in Mexico and brought up whole trainloads of men with their families, despite contract labor laws. The men in coming expect high wages and a return trip. But they soon find that a dollar a day is all that is paid, and moreover that that will not support a large family even in these courts. Work is not steady, and for the man

who cannot speak English there is no other job. Discouragement comes, and often the small earnings are drunk up in the ever-handy saloons. Stabbing affrays frequently follow, then the police station and the chain gang. The steadier element may seek work in the country. Meanwhile the railroads have sent to Mexico for more laborers! And so the courts shift and change like a kaleidoscope, and nobody to know the amount of hardship that is suffered in stoical silence.

The rent exacted for the wretched homes of the courts is of course exorbitant, as in all congested quarters. The people, not knowing English nor the necessity for sanitation (they are mostly from the rural districts), flock together wherever they may find shelter. The lowest rent is four dollars a month for a one-room shack that would not bring that price as kindling wood. With this goes the privilege of water from an outside common faucet, and the use of a toilet in common with from three to a dozen other families. When the heavy rains come in winter, imagine those shacks and tents that have no floors. Sick women lie on damp mattresses which are embedded in mud. Through the crazy roof and side walls water pours in at many points, and the household stays wet till the sun shines again.

Fortunately the sun is usually shining in Los Angeles, or perhaps unfortunately, for if it were not the very unsanitary conditions of the courts could not possibly be tolerated by the community at large. If it were not for the friendly Southern sun destroying disease germs the day long, frequent epidemics would draw attention to these places of incubation, and better sanitation and housing laws would be enacted. The city health officer can inspect and order landlords to clean the courts, but beyond that he has little authority.





A potent agency for the prevention of disease and its spread has been that of the office of district nurse. For nearly eight years the city has supported a nurse under the supervision of the College Settlement, and her work of inspection, advice and teaching, together with her co-operation with the health office, medical college and hospitals has been of inestimable value to the community.

Los Angeles already has a population of 200,000 and with reason anticipates being one of the largest cities of the land. It has its full share of the poor, the ignorant, and the vicious, for it is a Mecca for the unfortunate as well as the privileged classes. If no laws are

enacted to prevent the one-story crowding, and the many-storied crowding which will undoubtedly follow in its wake, we shall indeed be confronted by such conditions as have done incalculable harm in the older cities, and which with just a little foresight and common sense might be prevented here. The reckless zeal of a few individual landlords should not blind the community at large to the fact that congestion of any kind means but one thing, physical ill-health and moral depravity. Now is the time to pass and enforce laws which will insure enough air to the members of a household (the nurse found twenty-three sleepers in two tiny rooms); will provide for proper plumbing; and will limit the amount of a lot that may be covered with dwellings. —*Charities and The Commons, December, 1905.*

## SOCIETY TRANSACTIONS.

## THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.

ANNUAL MEETING, DECEMBER 15, 1905.

The retiring President, Dr. Jos. M. King, had requested Dr. Woods Hutchinson of Redlands, Cal., to deliver an address before the Association at the annual meeting. Dr. Hutchinson chose as his subject, "The Guild of Physic" and after tracing the historical development of our profession, took under consideration some present day tendencies and conditions, portraying in excellent manner, not only the strong but the weak points of the profession's mode of being and ethics. The address was full of pungent thought and suggestion and, like Dr. J. N. McCormack's talk along somewhat similar lines, was listened to with rapt attention. At the conclusion of the address, a vote of thanks was tendered the lecturer by the Association.

Under new business, Dr. J. A. McGarry discussed the advisability of a credit association among the physicians of the community, but no action was taken by the Society.

The Amendments to the Constitution and By-Laws by which, *one*, the annual dues were made five instead of four dollars; *two*, whereby but fifty cents was annually transferred to the medico-legal defense fund, thus allowing two dollars for the State Society, fifty cents for the Medico-Legal Defense fund, and two dollars and fifty cents for local needs; *three*, allowing the Council to elect honorary members, this honorary membership, however, not carrying with it membership in the State Society, at the expense of the County Association, and *four*, making the Secretary an ex-officio member of

the Council as well as the Board of Trustees, were all duly passed.

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The polls for the annual election were open from 12 m., to 6 p.m., at 324 Douglas Bldg., and from 7:30 to 9 p.m., at the meeting place of the Association, in the Art Gallery of the Blanchard Bldg., 4th floor, 233 South Broadway.

The tellers appointed were Doctors Hill Hastings, C. A. Jenks, Caroline McQuiston and H. G. McNeil.

The Board of Tellers reported 172 ballots cast, eleven of which were defective. The Association instructed the Board of Tellers to count such votes as did not conflict, and the Tellers then reported the following members elected to office for the year 1906: President, Dr. F. C. E. Mattison of Pasadena, Cal.; Secretary, Dr. Raymond G. Taylor of Los Angeles; Councilors (for three year terms), Dr. Stanley P. Black of Pasadena, Dr. George L. Cole of Los Angeles and Dr. Claire W. Murphy of Los Angeles.

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The referendum ordered by the Council, *one*, as regards contract work of physicians for lodges, at prices lower than the regular rates in the fee tables; and *two*, in regard to contract work at stated salaries by physicians, for mining and other corporations, both failed to be effective, since a total vote of one-half the membership, that is, 160 votes, was necessary and only about 150 votes were cast on these questions.

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The Council at its meeting of December 21st, re-elected Dr. John C. Ferbert as Treasurer of the Association, elected Dr. E. R. Smith to the Membership and Dr. A. Fenyes to the Medico-Legal committee.

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Physicians who were recently elected as members of the Los Angeles County

Medical Association are Doctors S. A. Austin, J. E. Wilson, P. H. Sunde and John L. Smith of Los Angeles; Ralph W. Avery, South Pasadena; Edwin H. McMillan, Redondo; Edith J. Claypole, J. M. Wilson and Wm. D. Turner of Pasadena.

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The attention of the members of the Association is called to the fact that the dues (\$5.00) for the year 1906 are now payable. Checks may be sent to the Secretary, Dr. Raymond G. Taylor or the Treasurer, Dr. John C. Fehbert, both in the Bradbury Building.

#### MEETING OF JANUARY 5TH, 1906.

The first paper of the evening, entitled "Scopolamine—Morphine Anaesthesia" was read by Dr. Z. T. Malaby of Pasadena, and gave a resumé of the action of the drug and its action in twenty-five of his own cases. The essayist was inclined to look very favorably upon the method, since given in proper dosage, he had noticed no bad effects and its action in lessening not only the amount of general anaesthetic necessary but also in doing away with post-operative nausea and distress, seemed to him to fully warrant its use.

*In the discussion of the paper,* Dr. Andrew Stewart Lobingier stated that he had no extensive personal experience with the method, and that he was inclined to ether, properly given, as the best of general anaesthetics. Attention was called to some recent literature in which several fatalities were attributed to scopolamine—morphine.

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The second paper of the evening, entitled "The Educational Treatment of Neurasthenia and the Hysterical Condition" was read by Dr. John T. Fisher and gave a general survey of the mode of treatment in those conditions. The paper was discussed by Dr. A. P. Williamson, superintendent of the State Hospital for the Insane, at Patton, Cal.,

and by Doctors E. R. Brainard, F. M. Pottenger, Dudley Fulton, Ross Moore, Theodore Davis, M. B. Campbell, Le-Moyne Wills and J. T. Fisher.

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The Eye, Ear, Nose and Throat Section of the Los Angeles County Medical Association met in the office of the chairman, Dr. W. D. Babcock, on Monday evening, January 8th. The following members were present: Doctors Babcock, Rogers, Harris, Macleish, Thorpe, Kelsey, Ellis, Dilworth, F. W. Miller, Roberts, R. W. Miller, McCoy, Lund, Fleming and Hastings.

Cases were shown as follows:

Dr. Rogers showed a patient with a tumor of the eye involving the Iris, diagnosed clinically as sarcoma. Dr. Macleish showed a case of "Hemorrhagic Glaucoma" and a case of "Traumatic Aniridia." Dr. Macleish also demonstrated a scheme for "Refraction Notation."

Dr. L. S. Thorpe, opened a discussion on "Foreign bodies in the Eye" and enumerated the bad results that sometimes follow improper attempts at their removal.

Dr. W. D. Dilworth was elected a member of the Society, and the applications of Drs. H. A. Kiefer and F. B. Kellogg were presented.

A committee was appointed, composed of Drs. Babcock, Ellis and Hastings, to assist in entertaining the visiting members at the meeting of the Pacific Coast Section of the Laryngological, Rhinological and Otological Society. Los Angeles has been doubly honored by the Society, in its selection as the next place of meeting and in making Dr. H. Bert Ellis its president. The last meeting of the Society on the Pacific Coast was in San Francisco.

This section of the Los Angeles County Medical Society has had interesting meetings throughout the year. All the meetings have been well attended and many very interesting cases shown to the Society and freely dis-



cussed. A separate room has been provided for the examination of patients and the clinical features of the Society have predominated over text-book discussions.

New officers were elected, as follows: Dr. W. W. Murphy, chairman, Dr. Hill Hastings, Clerk, Dr. L. S. Thorpe, Comarior.

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The Pomona Branch held a meeting on January 12th, at the residence of its Chairman, Dr. F. W. Thomas in Claremont, the programme being as follows:

1. Conditions that justify the opening of the abdominal cavity for the purposes of diagnosis and exploration.—Dr. Andrew Stewart Lobingier, Los Angeles, Cal.
2. The importance of proper dietary in the treatment of disease—Dr. Frank W. Thomas.

### SAN BERNARDINO COUNTY MEDICAL SOCIETY.

The San Bernardino County Medical Society met for its annual session at the Arrowhead Hot Springs at 2 p.m., December 13, 1905. Dr. G. W. Tape of the Arrowhead Hot Springs delivered an address of welcome which was responded to on behalf of the society by Dr. Hoell Tyler, the president. Dr. S. Y. Wynne of Redlands and Dr. Geo. K. Abbott of Loma Linda were elected members. The report for the year showed that the membership had increased from thirteen to forty-four. A vote of thanks was tendered Dr. Hurley, the secretary, for his successful administration. Officers were elected as follows: for president, Dr. Thomas M. Blythe of Redlands; first vice-president, Dr. Joseph A. Champion of Colton; second vice-president, Dr. Chas. E. Lee of Redlands; secretary, Dr. D. C. Strong of San Bernardino; treasurer, Dr. John H. Evans of Highlands. Dr. Frank W. Thomas read the first paper—

"Importance of a Proper Dietary in the

Treatment of Disease," which was discussed by Dr. Woods Hutchinson, Dr. Geo. K. Abbott, Dr. Geo. L. Cole, Dr. F. C. E. Mattison, Dr. Norman Bridge, Dr. John R. Haynes, Dr. LeMoyne Wills, Dr. C. C. Browning. Dr. C. Van-Zwalenburg read a paper entitled: "Shall we open the Abdomen in the Presence of Acute Inflammation of the Peritoneum." Dr. Andrew Stewart Lobingier read a paper on "The Conservative \*Surgery of the Tubes and Ovaries," illustrated by animals, drawings and diagrams. These papers were discussed by Dr. C. D. Lockwood, Dr. LeMoyne Wills, Dr. Beardsley, Dr. D. C. Strong and Dr. W. W. Beckett. The meeting then adjourned until 8 p.m., when the society reassembled in the great dining room as guests of the Arrowhead Hot Springs management and enjoyed an elegant dinner. At the close of the banquet the following toasts were responded to under the witty and eloquent leadership of Dr. James P. Booth of Los Angeles:

DR. JAMES P. BOOTH, *Toastmaster.*

"*Medicine and the Law.*"

Dr. Norman Bridge, Los Angeles.

"Remember they are men.  
Strain not the laws to make their tortures  
grievous."

\* \* \*

"*The Doctor and His Club.*"

Dr. Geo. L. Cole, Los Angeles.

"Why should a man whose blood is warm  
within  
Sit like his grandfater out in alabaster?"

\* \* \*

"*The Social Position of the Lemon.*"

Dr. W. Roblee, Riverside.

"Bear me Pomona to thy citron groves,  
To where the lemon and the piercing lime,  
With the deep orange glowing through the  
green,

Their lighter glories blend."

\* \* \*

"Should a man who has grown too old  
to give advice be Oslerized?"

Dr. Nichols, Los Angeles.

"When a wise man gives the better counse  
give me mine again."

\* \* \*

"*The Grand Old Imperial County from  
Needles the Desert Metropolis to On-*

*tario the home of the galvanized Canuck."*

Dr. J. N. Baylis, San Bernardino.

"I'll still stay to have thee still forget,  
Forgetting any other home but this."

\* \* \*

*"The Banquet as a Medicine,"*

Dr. Chas. E. Ide, Redlands.

"They eat, they drink and in communion  
sweet,  
Quaff immortality and joy."

\* \* \*

*"Does it Pay to Move,"*

Dr. Woods Hutchinson, Redlands.

"Perhaps it may turn out a son,  
Perhaps turn out a sermon."

*"The Advantages Derived from Following the Old Mormon Trail,"*

Dr. G. W. Tape, Arrowhead.

## EXAMINATION QUESTIONS.

CALIFORNIA STATE BOARD OF  
MEDICAL EXAMINER'S EXAMINATION,  
DECEMBER 20th-22nd,  
1905.

The State Board of Medical Examiners held their regular examination at the Girls' High School, Scott and Geary streets, December 20, 21 and 22. There were eighty applicants, thirty-seven of whom passed. The following are the questions that were asked:

### THERAPEUTICS AND MATERIA MEDICA.

1. State (a) the ordinary daily dose of ethyl alcohol for therapeutic purposes. (b) Per cent. of alcohol in whisky, brandy, sherry, koumyss.
2. Where and from what is asafoetida (gum resin) obtained? What are its therapeutic uses?
3. What is Epsom salt; Glauber's salt; Rochelle salt?
4. State the botanical name of Witch Hazel? What are its chief therapeutic uses? Upon what constituent do they chiefly depend?
5. What are the evidences of lead poisoning? Outline the treatment of both acute and chronic poisoning by lead.
6. Name the resin of May apple. State its therapeutic effect and dose.
7. What is the common name of Tr. Opil Camph.? Give its formula.
8. What is (a) the therapeutic effect of Rhamnus purshiana; (b) the dose of its fluid extract?
9. What is the origin of saccharum? of saccharin? of saccharum lactis? of glucose (dextrose)?
10. From what is Thymol obtained? What are its medicinal uses? To what form of intestinal parasite is it deemed specific?

### MEDICINE.

1. Give symptoms of intestinal perforation in typhoid fever.
2. Give symptoms of tubercular peritonitis.
3. Give morbid anatomy of gastric ulcer.
4. Give symptoms of intussusception of the bowel.
5. What condition of a patient would lead you to suspect embolism of the superior mesenteric artery?
6. Give symptoms of acute appendicitis.
7. Give physical signs of chronic dilatation of the stomach.

8. Describe the rash of variola, and of measles.
9. With what conditions may uraemia be confounded?
10. Give symptoms of suppurative cholecystitis.

### PHYSIOLOGY.

1. What are the important differences between human and cow's milk?
2. (a) How does oxygen reach the tissue? (b) How is carbon dioxide eliminated?
3. (a) Name the principal ductless glands. (b) Discuss the function of the spleen.
4. Describe fully the digestion which takes place in the small intestines.
5. (a) Describe the mechanism of the respiratory movements. (b) What is meant by the vesicular murmur?
6. Give the nerve supply of the muscles of the eye.
7. (a) Describe the paralysis caused by a destructive lesion limited to the posterior one-third of the posterior limb of the internal capsule. (b) Explain why in a hemiplegia of cerebral origin, the musculature of the paralyzed side reacts normally to electricity.
8. State the effect on the reflexes in destructive injuries to the following: (a) crossed pyramidal tract, (b) anterior horn cells of spinal cord, (c) peripheral nerves.
9. In the same lesions as question 8, what is the effect on the nutrition of the muscles.
10. Where is the origin of the following substances: (a) urea, (b) leucocytes, (c) erythrocytes, (d) pepsin, (e) taurocholic acid, (f) indol, (g) sebum, (h) fibrin, (i) vernix caseosa, (j) myosin.

### EXAMINATION IN SURGERY.

1. (a) Give surgical anatomy of complete inguinal hernia. (b) Describe a recognized operation for same.
2. Differentiate supracondylar fracture of humerus from backward dislocation of both bones of forearm.
3. (a) State position in which forearm should be dressed in fracture of radius above insertion of M. pronator radii teres. (b) Why?
4. (a) Describe Y-ligament (iliofemoral). (b) What effect has its tension on all hip-joint dislocations.
5. (a) Mention two causes of fistula in ano. (b) Operation for cure of same.
6. Give osseous features of following foot amputations: Hey's, Chopart's, Syme's and Pirogoff's.
7. Give three causes and treatment of non-union in fracture of long bone.
8. Describe operation and post-operative treatment for lacerated uterine cervix with chronic endocervicitis.
9. Describe preferable incision (near McBurney's point) for appendectomy. When contraindicated.

10. Give diagnosis of morbus coxarius.
  11. Operation for Intussusception var with and without gangrene.
- Answer ten questions only, numbered as above.

## CHEMISTRY.

1. What is meant by dissociation?
2. How is hydrochloric acid obtained, and what are its properties and by what tests may it be recognized?
3. What is an alloy and what is an amalgam?
4. What is reduced iron and how is it obtained?
5. What is Davy's solution?
6. Complete the following equations and write the names of each resulting compound under its formula:
7. Give the chemical composition of (a) Glauber's salts, (b) Epsom salts, (c) Rochelle salts.
8. State the names and general properties of the halogens.
9. How is liquid air obtained?
10. Give the toxicology of lead, i. e. sources of poisoning; tests; chemical antidotes; prophylaxis.

## ANATOMY

- Answer any ten questions, no more.
1. Describe the lower end of the humerus.
  2. What is the action of the muscles arising from the respective condyles of the humerus?
  3. Describe the aorta and name its abdominal branches.
  4. Name the humors of the eyeball. What are their uses?
  5. Describe the bronchial tubes.
  6. What organs lie within the right hypochondrium?
  7. Locate and describe the left kidney.
  8. Describe the colon.
  9. Describe and give the use of the cotyledary artery.
  10. Locate the principal lymphatic ducts and glands.
  11. Describe the median nerve.
  12. Describe the male urethra.
  13. Locate and describe the gall bladder and ducts.
  14. Describe the pancreas and duct.
  15. Describe the lris and ciliary body.

## PATHOLOGY

1. Describe in detail the pathological lesion in acute osteomyelitis.
2. Name in the order of frequency the lesions involving the pancreas.
3. Enumerate the causes of splenomegaly.

4. Name the portals of infection in the following diseases: Glanders, anthrax, erysipelas.
5. Describe gastric ulcer and name its complications.
6. Describe gross and microscopical changes in the bones in rickets.
7. Describe bronchial fistulae and cysts.
8. Describe microthecium and state its distribution.
9. Examination of gross pathological specimens.
10. Examination of microscopical specimens.

## BACTERIOLOGY

1. Describe in detail the technique of blood culture in the diagnosis of typhoid fever and state its value.
2. Describe the probable bacteriological findings in (a) pyosalpinx, (b) acute peritonitis, (c) meningitis.
3. Give the role of the bacillus pyocyaneus in human pathology.
4. How would you recognize the pneumococcus?
5. What diseases are believed to be caused by (a) higher fungi (b) protozoa?
6. What disease-producing bacteria are carried in water?
7. How can immunity be increased artificially?
8. Describe the precipitin reaction, and state its applications.
9. Define emmenagogue and discuss the value of the bacterial serums.
10. Describe the organism of relapsing fever.

## OBSTETRICS.

1. Describe Schultz's method in asphyxiation.
2. Describe the tissues in a transverse section of the funis from without in.
3. Define labor, and the difference between missed, postponed and protracted.
4. What naturally prevents postpartum hemorrhage in all cases of labor?
5. Give the symptoms, objective and subjective, of ectopic pregnancy.
6. Describe a case of normal labor (L. O. A.) through the different stages.
7. What are the causes of dystocia.
8. Describe the mechanism of labor in L. S. P.
9. How would you diagnose a case of dead fetus in utero.
10. Under what conditions should symphysiotomy be performed, and describe the operation.

## BOOK REVIEWS.

1. **TEXT BOOK OF PHYSIOLOGY**, for Medical Students and Physicians. By William H. Howell, Ph.D., M.D., LL.D., Professor of Physiology, Johns Hopkins University. Baltimore. Octavo volume of 938 pages, forty illustrations. Philadelphia and London, W. B. Saunders & Company, 1207, Cloth, \$4.00 net; half morocco, \$4.50 net.

This text-book of physiology is from the pen of Professor William H. Howell of Johns Hopkins University, the well known editor of the *American Text-Book of Physiology*, and bears the present mark of the W. B. Saunders Company. The present volume pre-

sents in compact and yet comprehensive form those major facts and principles of physiology with which all students should be familiar and places this information in such form and style as to be easily understood. While the author has carefully selected his material from original sources, he gives frequent references to the literature for those who may care to delve more deeply into various phases of the subject. The illustrations while not over-profuse, are good, and the work as a whole,



is of the character, such as would be expected from a physiologist of Dr. Howell's attainments. The book meets a need and is bound to be of real service to all who desire to keep in touch with this most important branch of medicine. Physiology is one of the things, none of us can know too much of, and Dr. Howell's name and authorship are a guarantee of sound, conservative and yet up-to-date teaching expounded in excellent manner.

BLAKISTON'S QUIZ COMPENDS. MEDICAL Chemistry, Inorganic and Organic, in-

cluding Urinary Analysis. By Henry Leffmann, A.M., M.D., Professor of Chemistry in the Woman's Medical College of Pennsylvania and in the Wagner Free Institute of Science. Fifth edition revised. Philadelphia. P. Blakiston's Son & Co., 1012 Walnut St. 1905.

The author writes in the preface a defense of quiz compends, saying: "It has been said that Alexander Pope is a poet whom everybody quotes and nobody reads. It may be said of compends that they are books that most professors and reviewers condemn and that nearly all students use." The price of this book is \$1.00.

## THERAPEUTICAL HINTS.

In the Spectator, Addison says: I am always very well pleased with Sunday, and think, if keeping holy the Seventh Day were only a human institution, it would be the best method that could have been thought of for the polishing and civilizing of mankind.

DECREASING BIRTH RATE IN FRANCE.—Consul Haynes of Rouen, in *Monthly Consular Reports*, says that there is no more worrying, persistent question in French economy than that of population. Nothing, he says, is so vexatious to the ambitious Frenchman than the fact that in Germany there are 600,000 more births annually than in France; and nothing more exasperating than the remark of von Moltke: "Every year by our birth rate we gain a battle over France." Mr. Haynes quotes statistics to show how this "nightmare of depopulation" has grown with every census in the last hundred years. In 1800 the population of Europe, in round numbers, was 98,000,000 of which 26,000,000 was French; thus France then had 26 per cent. of the population of Europe and now has only 11 per cent. At one time French was spoken all over the world; today it is the language of 45,000,000 people, while German is

spoken by 100,000,000 and English by 150,000,000. Until 1850 France, in point of population, had been the first of the great European nations, afterward the second, but now the sixth, with Italy closely following and threatening to pass France and to leave her seventh. French statesmen realize the danger to their country and are asking what is to become of France, while bills intended to remedy the evil are being introduced into the Legislature and societies are being formed all over the country. The National Alliance for Increasing the French Population was founded in 1896, its object being to point out the danger that threatens the country and to devise means to remedy it, and to secure appropriate legislation. The alliance states: France is on the way to become a third-class power; this tendency is due to the decreasing birth rate. It is as much a man's duty to contribute to the perpetuity of his country as to defend it in time of war. To bring up a child is a duty to the state equivalent to paying taxes. To acquit sufficiently this duty every family should have at least three children; therefore, families with more than three children should be exempt from taxation. The laws of inheritance and the present methods of

dividing property should be modified, as the present laws are not conducive to large families. Lastly, infants should be protected in order to diminish the mortality of the new born. One of the causes of this comparative depopulation of France is said to be the neglect of religious practices and beliefs. Other causes are said to be military service and the inheritance laws by which all land goes to the eldest son, thus assuring him a position and competence. Paternal selfishness is given as another; many fathers who would have been able to live in ease if they had a limited number of children are compelled to labor arduously to provide for their families.—*Journal, A. M. A.*

Kenniston & Root, 432 South Hill street, Los Angeles, offer a first class Birtman Vibrator for \$60.00, much less than cost.

"George Washington's Physicians, Their Friendship, and his Treatment during the President's last illness" is the title of a most interesting brochure which will be sent free of cost by J. S. Tyree, the Chemist, Washington, D.C., to any reputable physician upon request. The illustrations in this booklet are excellent.

We gladly call attention to the formula of "Phenoseptine" which appears in our advertising pages. This is certainly an excellent antiseptic solution, and the fact that it is manufactured in Los Angeles should at least lead Los Angeles physicians to give it a trial. By mailing a postal card with address to Chemical Co., Los Angeles, a 3 oz. box will be sent free of charge.

### HEMIPLEGIA.

T. H. Weisenburg, Philadelphia (*Journal A. M. A.*, February 25), has studied 160 cases of hemiplegia in the Philadelphia General Hospital with special reference to heredity, pain, muscular atrophies, respiration, edema and the arthropathies, vasomotor disturbances

and hemichorea. In 109 cases where the facts could be ascertained heredity was present in 14 and strongly manifested in 5 cases. In 17 there was prehemiplegic pain, which is accounted for as possibly due, in persistent cases, to cerebral congestion or actual small hemorrhage in the sensory pathway. Twenty-seven had post-hemiplegia pains. In 30 cases there was either total or partial anesthesia, and in the majority some pains. It appears that pain in hemiplegia is most likely to occur in cases with sensory changes. Weisenburg confirms Hughlin Jackson's observation of the greater expansion of the upper portion of the chest on the paralyzed side during quiet respiration, but he also found, and Dr. Spiller confirmed the observation, that at the end of ordinary or quiet respiration the chest retracted more than on the paralyzed side, thus showing greater power of expelling the air on the sound side and actual weakening of the lung of the affected side with diminished respiratory movements. He reports a case of intense edema on the paralyzed side; in two other cases there was edema of the paralyzed hand. Among vasomotor disturbances he notices the rare occurrence of anhidrosis in one of his patients. Weisenburg considers Bonhoeffer's explanation of a lesion in the extension of subcortical ganglia as the most probable theory concerning posthemiplegic chorea. In every one of his 160 cases there was some muscular atrophy, more marked as the paralysis was marked, affecting the upper more than the lower limb and, in the majority of cases, accompanied with sensory symptoms. In a large number considerable atrophy was also observed on the so-called sound side. Arthropathies as described by Marie occur in most cases of hemiplegia. They affect mostly the shoulder joint, but with marked contractures other joints also may be involved. Weisenburg thinks the cause is probably the forced immobility plus the pulling on the articulations and tendons by the weight of the paralyzed member. Lesions of cells of the anterior horns are not common in hemiplegia, and, in the cases examined, no pathologic changes were found here. He notes, however, one or two peculiar cases, and in two or three of his patients there was painless arthritic conditions suggesting somewhat the arthropathies of chronic spinal disease. This paper is to be followed by a pathologic study of hemiplegia.

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DR. WALTER LANDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## ENTERO—PTOSIS IN WOMEN.\*

BY L. G. VISSCHER, M. D., LOS ANGELES, CAL., LECTURER ON DISEASES OF THE  
STOMACH AND BOWELS, COLLEGE OF MEDICINE, UNIVERSITY OF SOUTHERN  
CALIFORNIA.

In speaking of entero-ptosis or splanchno-ptosis, we are subject to a word suggestion conveyed by "ptosis," which means *descent*. Especially plausible is this thought of a dropping down of a viscus, when this is heavy; nephro-ptosis is evidently a kidney, which by a fall, a jar, has been jolted down, or which by a rapid loss of encapsulating fat has sunken down into the abdominal cavity, like a brick through melting ice. Colo-ptosis is a colon filled with stagnating stool, dragged down by its weight, not sufficiently suspended by its mesocolon, and not properly supported by an relaxed atonic abdominal wall. Hepato-ptosis is a favorite of later date, gladly welcomed in this down-grade going crowd, as an especially heavy one, being on top of the other fellows, pushing them down. Gastro-ptosis is evidently an over-filled stomach sagging down, pulling at its moorings and weighed down by omentum and over-filled colon. Spleno-ptosis similar, and

all of this so much more easily conceivable when the bottom is knocked out of this abdominal barrel by perineal laceration or its wall bursted by diastasis of the recti. Of late, in cardio-ptosis, we find the heart beating away the time of our terrestrial existence, two inches below par! What is there left but lower the head in despair, overlooking this downfall of human flesh.

As a consequence of this auto-suggestion, ptosis, with its concomitants of weight, insufficient suspension and lack of support, comes the suggestive therapeutics of horizontal rest, Trendelenburg's position, bandaging and surgical fixing, anchoring, stitching, floor building and shortening of ligaments. Without going too far in our attack on existing terminology or the popular explanation of highly complex conditions, let us ask whether a large hyper-trophic liver, or a cancerous, or syphilitic liver, or a liver with a large central abscess or a hydatid, is sunken down in the belly? Is the large white kidney, or the

\*Read at the Thirty-fifth Semi-Annual Session of the Southern California Medical Society held on December 6th, 1905, at Los Angeles, Cal.



sarcomatous kidney specially prolapsed? Is the leukaemic or malarial spleen wandering?

Some weeks ago, a woman came for advice presenting a large ventral hernia, capacity about three quarts, caused by stretching of an abdominal pan-hysterectomy scar. I was able to introduce my whole hand through the opening, and as the woman had been in this condition for over a year, and had lost 80 lbs., I eagerly felt for movable kidney, or liver. But I found nothing other than a dilated and prolapsed stomach and colon.

Gentlemen, there is more to entero-ptosis than erect posture and gravity; and therefore we should understand that in splanchno-ptosis, single or multiple, the organs in question occupy a position by choice or by compulsion, different from what we normally find. Why these organs occupy this place has been explained in various ways, and the authors of the different etiologies have tried their very best to make their explanation omnivalent. Allow me to mention from the beginning that the placement of the abdominal viscera on a lower plane than is normally found is constant and normal in the fetus, in the neonatus and during the first half year of early infancy, as Henle has pictured in his topographical anatomy: the stomach stands vertical, the ascending and transverse colon merge into one straight gut; the right kidney is held down upon the concave iliac bone by the liver, which almost touches the cresta ilei, *and all this in a foetus which has been standing on its head all its life.*

Very recently, Joseph Rosengart, gives, well supported by embryological and anatomical dissections, his brilliant etiology of entero-ptosis, looking upon it as an arrest of development in a stage of foetal life, or very early infancy. Entero-ptosis (and when I use this word let us please agree that because a fellow is sitting at the foot of a

stairway this does not necessarily mean that he once was upstairs and has been kicked down!) entero-ptosis is far from uncommon in children, *but* it is far more frequent in adults, therefore it is an acquired condition at that age. Still it is easily understood that the organs will go down into their early position by a cessation of the influences, which lifted them up, or by accidental changes in the adult life, which introduce into the abdominal equilibrium, influences contrary to those which marked their developmental rise. This leads us into the midst of clinical observation, anatomical study and pictorial journalism; Buster Brown is right where he *resolves*: "It is up to you to get the liver; medicine won't do it; joy and temperance and repose, slam the door on the doctor's nose."

The liver is the real hub in entero-ptosis; but only of late has this been recognized. Why? Because the determination of the liver boundaries is technically difficult. Percussion is insufficient and yet excepting the use of x-rays, on palpation solely must we rely. Up to '87 only nine cases of *ectopia hepatis* with clinical symptoms of consequence were known, the oldest case being described in 1866 by Cantani. In 1895 Graham collected 70 cases; but to Max Einhorn do we owe our knowledge of movable liver, which he asserts can be found to some degree in 3 and 7-10 per cent. of all persons with indigestion. Rosengart's etiology lends great support to this statement; and even Glenard, who in '85 grouped the topographical visceral ectopia and the clinical neurasthenia and indigestion together as "entero-ptosis" has now abandoned his original view, that a descent of the hepatic flexure followed by a dislocation of the transverse colon is the primary disturbance in splanchno-ptosis. Let us go back to early infancy. Respiratory motions of the diaphragm (and this from now on all through life) produces two changes;

1st, by lateral and posterior diaphragmatic contraction the liver rotates posteriorly downward, anteriorly upward around a transversal horizontal axis and 2nd, by the change in the blood circulation the liver reduces relatively in size, the combined effect being a rise. Therewith a rise of the right kidney following the gentle pull of its main blood vessels and peritoneal folds. The vertical stomach, after feeding, (and especially overfeeding) sacculates. As the right kidney climbs, it makes place for the ascending colon, which develops its hepatic flexure according to the continual growth of the enteron, which necessitates coiling. So far, no sex difference, little boy and girl alike. We will hurriedly pass by the causes common to both sexes of arrest of this development in childhood; gastric overdistension, constipation, general debility, rachitic compression of the lower thorax with its immediate and permanent pressure on the upper viscera, and especially the liver, whooping cough, bronchitis and eventual emphysema, all equally harmful to both boy and girl. But soon the boy strides forward to grasp the chance of his male birth; independence (sic!) mobility, running, crying, climbing, fighting, all influences which favor chest capacity, diaphragmatic and low thoracic breathing, regular bowel function and bowel growth, strong abdominal muscles and therewith high intra-abdominal pressure. The girl is kept more at home, more nice; she walks more than runs, giggles more than laughs, teases more than fights and gets more than is good for her. Result: more frequent constipation, lax tissues, large abdomen well known in young schoolgirls. A boy eats more of the forbidden fruit, is more of a pantry-thief, pays with green apple belly-ache. A girl eats candy, lives in the pantry and pays with bilious attack. Boys wear suspenders; girls, skirtbands. They get to be 13 years or so, the road splits in earnest with

continual parallelism though and constant crossings! We, as gynaecologists say goodbye to the boy, temporarily, till we hear of him again. The girl matures, the small infantile uterus develops with its adnexa and the enormous weighty blood supply pertaining to this system. Lucky the girl who at this time is not constipated, nor develops at this age or somewhat later chlorosis, part cause, part sequel of constipation. Anaemia and chlorosis cause stunted development, atony of unstriped fibre in abdominal distension of bowel, sacculations displacements and abnormal tractions on the mesentery. Two influences now harm the growing girl. First and more permanent, her skirtbands and corset. Second, the lack of hygienic attention paid to her menstrual period.

As differential characteristic of sex, the ribs in women have a greater obliquity, the space of the lower thorax below the diaphragm is narrower, the liver and spleen can easily by contraction over the lower ribs be pushed downward; perivertebral fossae in which the kidneys are embedded are instead of funnel shaped cylindrical, letting the kidneys more readily slip downward if pressed from above; the stomach, after meals especially, if more than normally distended by gas does not find space and is "suggested" downward, the pelvis is wider, built for future pregnancy. Furthermore, the woman within her encasing cannot breathe sufficiently with the lower portions of the lung, which has a manifold influence on venous stagnation in the cava inferior, and all the veins tributary to it. Since every woman, if you inquire as to her lacing, will immediately take hold of her corset and invite you to slide your hand between corset and body to let you feel how loose it is, it is well to know that *Dickinson* estimates the total pressure of the corset between 30 and 80 pounds, and found the capacity for expansion of the

chest restricted by one fifth with the corset on; the pelvic floor bulged downward by tight lacing one third of an inch.

The corset is a chronic and recurrent trauma, and while it contributes to the bodily balance it is injuring the sense of equilibrium and muscular sense by lack of use. A woman leaving off her corset feels helpless and awkward; she exhibits a swaying gait and practically has to learn over how to walk properly. The *menstrual period* with its irrational management in the whole life of the average woman, is the source of untold suffering invalidism and of what concerns us here, entero-ptosis. How affects menstruation the abdominal contents? First, the active hyperaemia of the pelvis, includes the rectum, caecum and kidney. If there is no displacement of pelvic organs, a more free bowel evacuation is the rule; if there is abnormal bend or displacement of the uterus and adnexa and sacculated or truly prolapsed sigmoid and overdistended coecum, there will be passive congestion and constipation and its *circulus vitiosus*. It is not so much during the first days of menstruation that rest should be insisted upon as many women actually develop a remarkable restlessness and industriousness during these days (apart from the fact that pain and cramps can better be endured while going about, than by standing or lying still). But when the flow is well established and during a day or two or more afterwards, when the passive congestion has to be relieved, rest should be kept.

It is well known, how during the period by reflectory inhibition digestion is very slow, even with normal digestive organs, the appetite is less; but in the great majority digestive complaints are numerous and the host of "ptotics" are suffering. Many a sub-acute icterus or attack of colica mucosa or exacerbation of chronic appendicitis is indirectly traceable to a mismanaged

menstrual period, which I therefore claim to be a chronic and periodical trauma to the health of the grown-up woman, and a hinderance in the development of the growing girl. The influence of normal pregnancy and childbirth in a healthy and well-living woman is not contributory to ptosis. Unless the pregnancies are too numerous or too close together (which is a morbid state, a consequence of a lack in matrimonial ethics) or when they are complicated by laceration unrepaired, they result in not only a relaxed abdomen, reduced power of defecation, necessitating undue diaphragmatic straining and causing stagnation, but also hyperaemia (passive) of the abdominal contents; lowered intra-abdominal pressure and undernourishment of the body, inanition of muscle, of nerve.

The scope of this paper does not allow a discussion of all the factors contributing to entero-ptosis, nor the analysis of the different theories and views. We here only consider the inter-relation of the female sex and the displacement. Neither can we enter into a full diagnosis of entero-ptosis, which includes the use of all our clinical investigation. Characteristic *anamnesis and symptomatology*: neurasthenia, stomach and bowel complaint.

*Inspection*: Attitude and conformation of abdomen and lower thorax. Do not overlook the ribs.

*Artificial Inspection*: 1st, by x-rays and bismuth; 2nd, by gastro and colon-diaphny with intra-abdominal lamps with or without fluorescent filling.

*Percussion*: In unaltered state, before and after catharsis, in artificial conditions, alternate filling of colon and stomach with gas and water.

*Auscultation*: The use of Chomel's sound of clapotage (splashing) and production of artificial sounds in the stomach.



*Palpitation:* The different attitudes of the patient. The means of palpitating the liver edge; a spleen; a colon contracted; a sigmoid flexure and a movable kidney.

Examination in the office, in the hot bath, and under an anesthetic.

But a few remarks; differentiate between an atonic stomach, a dilated stomach and a displaced stomach. A stomach is atonic when it behooves more than 7 hours for the transfer of Reigel's mixed testmeal; it is dilated when it contains food in the morning hours after the night's fast; it is displaced only when the lesser curvature can be outlined.

2nd. A pancreas is hardly ever palpable; the transverse mass often found at navel height or below is Glenard's cord colique transverse. 3rd. The elongated mass in the left iliac region is the contracted sigmoid. 4th. The navel is often peculiarly hidden in a fold caused by traction of the lig teres in hepato-ptosis. (Glenard's sign.)

5th. The tenth rib is found often movable or floating considered by Stiller as a congenital, ptotic and neurasthenic stigma. 6th. There has been described very recently by de Langenhagen, (*Presse Medicale*, 1904, May 14) a false movable kidney, being in one instance a kinked hepatic flexure; in others an intersusception mistaken for kidney in Dietl crisis. 7th. Chomel's sigh of clapotage is very useful; only bowel flushing and stomach dilatation must be excluded. We are only in the beginning of our knowledge of entero-ptosis; but this much has to be well and constantly kept before our mind, the essential pathological conditions are inanition and lower intra-abdominal pressure; the symptoms are displacement, traction, sacculation, disturbed function of peristalsis, blood stagnation and disturbed splanchnosympathetic nerve function. Now inanition does not always mean leanness, many a woman is thin and wiry and

has no complaints as mentioned; many a woman who has borne children in numbers with a flabby abdominal skin, no prae-peritoneal fat, a moderate perineal laceration at that, will have kidneys and stomach and colon in place. And again, many a woman stout and fleshy with one or two children has entero-ptosis. There is an entero-ptosis of the fat and of the lean. It is a well known observation that many a ptotic woman feels better and is free from her digestive complaints in the latter half of pregnancy, it is said, because the organs are lifted up, true. But also because the intra abdominal pressure both intra peritoneal and intra vascular is increased; because the women often take better care of themselves and pay more attention to their diet and bowel regulations and keep off the street during business hours.

What influence does entero-ptosis have on the pelvic organs? First, the latter often share in the common cause of inanition. Second, there is the deleterious influence of constipation and the weight and pressure of the over-filled colon, and of the hard scybala in the sigmoid and over the rectal pouch; not only are normally placed pelvic organs displaced, or existing displacements aggravated, but also the return-venous circulation is hampered and a chronic passive congestion is the result, with all its symptoms; existing endometritis is made permanent; menstruation is of longer duration and often more profuse; backache and bearing down and the reflex vertical headache are indirect consequences. There is more: it is admitted that the colus communis bacillus may through lymph communication travel from a constipated bowel mucous to a tube or hydrosalpinx and all of you will remember the animated discussion arising in the 53rd meeting of the A. M. A. after Dr. Goelet of New York had read his paper, in which he demonstrated how a movable right kidney will press up-

on the ovarian vein (and ureter) especially if the abdomen be compressed by corset or skirts; how this pressure being only at work interruptedly, that is, during the erect posture of the woman, is more harmful than if it were constantly present, as in the latter case other channels for the return circulation would be established. It is this argument which ever since has lead many a surgeon-gynaecologist to the anchoring of the kidney, and to the accusation that abdominal bandages would do more harm than good.

Before treatment, what is there in prophylaxis? I advise all open air life possible, emancipation of the young girl (this means the old country!) I advise the mothers to continue in their childstudy, but with it to see that their girls (and boys) eat right (and they don't); see to it that their bowels move right. I advise the mothers that they shall enforce a proper management of their daughters menstrual period, with decision and determination, and I laud the old Jewish custom to look upon the menstruating girl and woman as unclean. Pity the ones who have to work in the house or in the store or in the school. The ones who could do better but don't, if it be ignorance, *teach* them; if it is unwilling, *blame* them; *noblesse oblige*.

In this glorious sunny land of ours, thankful be it said, the child girl and the young lady leads an exceptional healthful life; she plays more than basketball; she bowls, boxes, she fences, she swims, she rides, she rows, she dances (and how!). With due care then and hygienic wisdom keep the growing generation in this California land healthy and strong as she is beautiful; she is, and then will be for all times, the pride of this commonwealth and the wonder of all the world.

Shall a ptotic woman ride horseback? After some rest and toning up, yes, if not the kidney be movable over the second degree. *Treatment*, before

all, taking duly into consideration the special etiology of the individual case, must be causal and not symptomatic. Meeting the causal indication, we must recognize in its full light what Blake calls the "perpetuating cause." Enteroptosis, in any of its forms once established, is *perpetuated* by the continuation of its essentials: inanition, low intra abdominal pressure and consequent venous stasis. I cannot help comparing enteroptosis with relaxed scrotum and low placed testicle. Who expects a cure from putting the man on his back, or from letting him wear a tightly fitting suspensory, or to submit him to such an operation as "orchidopexy" and I do not think that the scrotum is banded or plastered up for any other cause but acute epididymitis. The *rationale* of mere rest (*horizontal*) is partially, to relieve the impeded venous circulation in the misplaced organs, relieving stretching and tension and angulation of the mesenteric veins; further to enforce an overfeeding, thereby restoring tone, making blood, heighten tension, accumulating fat, giving sleep to the wornout central nervous system. We add to it light *abdominal massage*, again for the improvement of venous circulation, and often for the subsequent improvement of regular peristalsis; *general massage* for its manifold influence on general metabolism, and *spinal massage* for its undeniable influence over abdominal and pelvic circulation and tone, and when we make our patients raise the foot of the bed and assume the knee chest position oftentimes during the 24 hours, we treat our congested abdomen as we treat similar conditions of the limbs by vertical suspension.

*Electricity* partly faradic, partly galvanic, by preference sinusoidal, in the hands of experts is undoubtedly of the greatest benefit. The electricity may be applied ventro-spinal; or intra-gastric; the different pole moving over

the abdominal parietes and along the spine. Of our pharmacopea we select iron, arsenic, hypophosphites, lecithin, quinine, manganese, strychnine and ergot. In certain phases of our treatment, we need sedatives, to quiet the excited brain, spine and sympathetic. Fresh air, sunshine and active, invigorating exercise, light sport, mild climbing, rowing, swimming are necessary. More there is. Physical culture wisely employed does marvels. We should insist on proper posture, retraction of abdomen and chin, advising our patient to be conscious of what they are doing, abolish the rocking chair, use only couch or straight chair and sit straight. Deep breathing in open air different times a day, and special exercise for the muscles of abdomen and back. When in a proper place, we find in hydrotherapeutics a mighty bond; hot packs, cold douches, Scottish douches in the epigastrium do a great deal.

Of the greatest value is proper feeding, which means in these patients the selection of a cost adequate to the disturbed mobility of stomach and bowels. Gastric secretion is in 8 out of 10 cases greatly increased, intestinal digestion is disturbed, by high acidity, secretory and fermentative. Reduction therefore of liquid taken with meals and fluid regulation during 24 hours is necessary.

If milk is tolerated it is of the greatest value. So are malted beverages. Starches in hyperacidity are best reduced and where colica mucosa, so very often an accompaniment of enteroptosis be present, the diet arranged accordingly. The administration of the different digestives is rarely of any help. Bowel antiseptics and absorbents, especially charcoal, carbolic acid, creosote, thymol, menthol, resorcin, B-naphthol, bismuth, salicylate, have their temporary indication. Inasmuch as constipation, appendicitis (chronic) catarrh of gall bladder, even stones, chronic gastritis, colitis, or colica mucosa, hemorrhoids may be present, we

have to direct our measures toward the complication. Especially in the selection of laxatives have we to exercise caution and generally these patients are harmed by active purgation, their bowels actually long for something else but liquid and wind! and there is no harm, but good, in letting the bowels *have their fill*.

All this will further be supported by a well measured and fitted low abdominal corset, leaving the ninth and twelfth ribs free from any pressure. Pads are useless for the purpose they are manufactured for, as if a pad could successfully hold or grasp a displaced organ! It is well said: a postage stamp would do the same. We do not want it, if we can only reinforce the abdominal wall temporarily by restraining support, further relieve the upper abdomen with liver and stomach in first instance from pressure inward and downward. The corset should be measured and put on in Gallant's semiopisthotonic position. Rose's plasterbandaging has given in his hands good results, also his Unna's glue plaster bandage. In many instances the wearing of perineal bandage, or a tightly drawn napkin is accompanied by great relief.

I am almost through with my subject, but I see the wondering face of the surgeons. Where do they come in? Here is your share, gentlemen. *All* the pelvic surgery necessary, but I urge conservatism. I ask you regularly to cure hernia, to excise relaxed scar tissue; to repair diastasis of the recti; even to put folds in the abdominal fasciae, to reduce abdominal capacity. Movable kidney, when patients suffer from Dietl-crises, or when there are repeated attacks of jaundice, when the kidney is the only dislocated organ causing damage. All the rest I keep away from you, as long as I can, that is to say, unless the mentioned methods combined fail to bring about a cure in about half a year's time, or over. I will ask your help in certain cases to



## 10 WHY WE SHOULD MAKE THOROUGH EXAMINATIONS.

overcome the consequences, the sequelae of enteroptosis. You may shorten a ligament or you may perform a gastro-enterostomy in a ptotic patient, not for her ptosis, but for stasis in the stomach.

I say emphatically that you surgeons cannot cure enteroptosis, even not if you stitch up kidney, stomach, colon and liver at the same time. You can only help the repair of some of the sequelae and that only at great risk. You surgeons can no more cure enteroptosis by stitching or anchoring than you can cure cirrhosis hepatis by tapping the abdomen or large white kidney by ankle incision, because you leave the essential causes unaltered; inheritance, malnutrition, wrong habits, nerve and muscle degeneration and

lowered intra-abdominal tension. I will go even farther and accuse you, jokingly, be it said, in kindness and good fellowship, accuse you of aggravating *entero-ptosis*, by letting your patients, after childbirth, pan-hysterec-tomy, removal of tumors, appendicitis, even minor pelvic operations, get up too soon, get home too soon, underfed, improperly fed, the abdomen full of wind, drained by saline purges and riddled by laxative pills.

The treatment of entero-ptosis means rebuilding of the organisms, that means blood and fat. We do that by air, exercise, rest, feeding, bandaging, electricity, drugs; during a long time; not by knife, thread and needle in a jiffy!

Laughlin Building

## WHY WE SHOULD MAKE THOROUGH EXAMINATIONS OF THE DIGESTIVE SYSTEM.\*

BY BOARDMAN REED, M.D., PHILADELPHIA, PA.

Recent graduates in medicine have generally been taught much more about diseases and derangements of the digestive system than was ever known until within the last two or three decades. A good many of them are able to diagnose the ptoses of the abdominal viscera, including especially the exceedingly frequent downward displacement of the stomach and right kidney—gastroptosis and nephroptosis—as well as lowered motor power in the walls of the stomach and intestines and can make the simpler tests of the gastric contents and feces.

But, unfortunately, those of us who sat on the benches twenty-five or more years ago, were nothing like so well instructed in this respect, and have only been able to fill the great hiatus in our medical training by taking post-graduate courses which are not practicable for all doctors.

And in the East, at least, it is quite exceptional, even in stubborn chronic cases of obscure disease, that the digestive organs are investigated by the modern exact methods, unless a tumor has been found in the epigastrium or there should be pronounced symptoms of gastric ulcer or cancer. Very often then the expert examination comes too late.

This neglect, it seems to me, is much to be deplored. Yet I would not advise introducing a tube, with the object of testing the gastric contents or washing out the stomach at once, in even all doubtful cases. Unless there is manifestly present a serious dyscrasia, or the evidences of such a dangerous affection as tuberculosis, where the vital powers need to be fortified to the utmost and at the earliest possible moment to ensure a victory in the life and death struggle which must then be

\*Read by invitation before the Los Angeles County Medical Association on February 2, 1906.

fought to a finish, it is well enough to trust for awhile to the usual hygienic and therapeutic measures.

Even in the case of tuberculosis it should be safe to rely upon the well approved remedies without any help from the stomach tube so long as all goes well and the patient is improving. But in every chronic case, at least, there should certainly be an external examination of the abdomen to determine the size and position of the more important viscera. The method of doing this without the help of any intra-gastric instrument has been fully described by me elsewhere.<sup>(1.)</sup> It can be done easily by any one fairly expert in percussion after a very little special instruction, and affords so much information of the greatest value in cases of chronic ill health, that it ought never to be omitted, whether or not the symptoms point to the alimentary tract. For it is well known that in many of the more serious forms of disease in that tract, the only symptoms for a long time may be those referred to other parts. Among such symptoms which are particularly common, are headaches, insomnia, nervous debility, mental depression, etc.—in short the more frequent manifestations of neurasthenia.

Most of the dermatoses not due to syphilis probably have their origin either in indigestion or a faulty metabolism; and diabetes mellitus, a prolific brood of liver diseases and a large share of the more chronic and insidious affections of the heart, arteries and kidneys may be traced to one of the same causes. Even the catarrhs of the upper respiratory tract are now placed by Kyle <sup>(2.)</sup> and other leading rhinologists in the same category.

Surely, then, in all those forms of disease which do not clearly have their seat elsewhere and are not of exogenous origin, it is quite as important to investigate thoroughly the alimentary tract as the other regions of the body. It ought to be much more im-

portant, for example, in an obscure chronic affection, to interrogate the bloodmaking organs than those of the reproductive system—those of the upper abdomen than those of the pelvis—though during the past twenty years the contrary course has been the fashion. Nearly all of us who may be classed among the older practitioners, were trained to believe it our duty to examine the uterus and adnexa in the case of all obscurely ailing women, while comparatively few of us, I fear, make it a rule always to examine the other viscera even externally.

And in addressing a body of physicians who see much of phthisis, it is peculiarly appropriate to emphasize the great importance of studying closely both the organic condition and functional behavior of the digestive organs in every case of tuberculosis, which is not steadily improving without it. In the treatment of no disease, now-a-days, is it so imperative that the nutrition shall be kept at its highest possible level in order to obtain a cure. And how can such a state of the nutrition be secured and maintained, unless the stomach, liver, pancreas and intestines are all in an approximately normal condition and performing their functions healthfully?

It is claimed by some of our ablest authorities, including Stockton,<sup>(3.)</sup> that the stomach, liver, right kidney and at least a portion of the intestines, most commonly the colon, are either all or some one of them, displaced downward more or less in one half of all civilized women. In many of them the ptosis is very marked, and it is a frequent experience to find the stomach and transverse colon resting on the pelvic organs. Furthermore a considerable proportion of both men and women have dilated stomachs. Since, as a rule, only persons with a relatively low vitality acquire phthisis, it is fair to infer that a greater percentage of the victims of the great white plague than others would be found, upon careful examination, to

be suffering from either dilatation of the stomach and intestines, or from displacements of the viscera or both. Such abnormalities must lessen markedly the chances of effecting a cure of tuberculosis by the methods now most in vogue—the fullest practicable alimentation and oxygenation. And they are in a very large proportion of cases amenable to skilled treatment. They can nearly always be greatly improved and often cured radically by methods which are described in the text books on the subject—with especial fullness in my own work.<sup>(1)</sup>

In regard to the aberrations of the secretory function of the stomach, I have always been conservative and do not believe in beginning the treatment of every slight dyspepsia by putting a tube or other instrument into that viscus. Many of such ailments—perhaps I should say most of them—are due to a faulty innervation or circulation in the glands or muscles of the digestive organs. These will often yield to an improved personal hygiene or to rest of an over-strained brain and nerves with a toning-up of the nervous and circulatory systems by appropriate remedies, assisted by a generous diet. But when these measures do not promptly prove effective by themselves, and especially when the tonics and full feeding are not well borne, there should be at once a thorough testing of the secretory and motor functions of the stomach with in addition, when necessary, a chemical and microscopical examination of the feces.

Such examinations are exceedingly important in treating the severer and more intractable cases of neurasthenia, as well as in various other affections and it seems to me, are doubly important in cases of tuberculosis of the lungs which are not progressing favorably. In this disease even a few months of routine treatment, without full examinations, in the precious period of incipency, while we are hoping for a gain which we fail to obtain because of some entirely re-

movable fault in the digestive system, may occasionally prevent an otherwise possible recovery.

I will forbear to prolong this paper by making detailed reports of cases observed in my practice which would illustrate and forcibly emphasize the advice here given. It should be self-evident that whatever will increase our knowledge of the vitally important processes going on in what may be called the great laboratory of the body, will help us to assist Nature in effecting the cure.

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- (4) *Loc. cit.*

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#### DISCUSSION OF DR. REED'S PAPER.

DR. L. G. VISSCHER:—Dr. Reed may be considered one of our very best teachers in diseases of the gastro-intestinal system. No man in this country has given to the general practitioner the full benefit of theoretical knowledge and of complete command of practical detail and experience as gathered in a long clinical practice than has Dr. Reed. In his valuable series of articles which appeared in the *International Magazine* and which have more recently been presented in book form. None of the many articles and works by other American authors can be said to be as clearly written or as suitable to the evening reading of the general practitioner as are Dr. Reed's publications.

What Dr. Reed has told us this evening is all very true. The very complexity of normal growth and metabolism and its intimate relationship to the gastro-intestinal system has been the reason why, for myself, my efforts have remained confined to the diseases of this system. To give advice in diseases of the gastro-intestinal system it is necessary to know the exact nature of the processes at fault, in other words, to be able not only to observe and give due weight to all clinical symptoms but to be able to make complete chemical analyses also. There is no need to be afraid of diseases of the gastro-intestinal tract and it is wrong to believe that such diseases are always to be referred to a specialist. Gastro-intestinal diseases have such wide ramifications with the other systems of the body that they come within the scope of the general practitioner; in fact, cannot, so far as successful



treatment is concerned, be made a narrow specialty. All that is required in diagnosis and treatment is time, care and practice. Aim to do more than to give a snap shot diagnosis and to simply treat symptoms. In regard to Dr. Reed's remarks on the intimate relationship of the gastro-intestinal tract to cure in pulmonary tuberculosis, I have no extended experience with this class of patients. I would only call attention to the dangers of over-feeding in these debilitated persons. A study of the muscular power and chemical function of the gastro-intestinal tract is always desirable in this disease and as Dr. Reed has well said, it is not necessary to invariably resort to the stomach tube in the treatment of diseases of the gastro-intestinal system.

DR. STANLEY BLACK:—Gastro-intestinal diseases present two sides; one, the clinical and two, the laboratory. Neither can be independent of the other, if practice is to have successful results. Often specimens are sent me for chemical analysis and I am supposed to indicate therefrom the exact diagnosis and treatment. This is asking too much of the laboratory factor. Thorough physical and clinical examination should always come first. This done, then chemical analysis can give much additional data and aid.

DR. C. LEE KING:—Referred to Dr. Cabot's remarks on laboratory methods, in which Dr. Cabot stated that much of the technique, which seemed very intricate, was not more so than tying a dress scarf.

DR. GEORGE L. COLE:—Would emphasize the need of clinical examination. Chemical analyses are too apt, at times, to make us reluctant to change our diagnoses, whereas, if clinical symptoms had been fully weighed this would not have been the case. Too much energy has been put in on scientific diagnosis by some men, the patient then, as has been said, dying of "scientific neglect."

DR. DUDLEY FULTON:—Had been struck with the prevalence of the ptosis of abdominal viscera in women (almost 50 per cent.) Had lately been having excellent results from the use of Dr. Rose's belt of wide adhesive plaster. It is easily applied and gives not only prompt local relief and support, but relieves also headache and general symptoms. Would inquire whether one could expect permanent results after two to three months application of the bandage, as asserted by Rose.

DR. F. M. POTTENGER:—Had been especially interested in the remarks on gastro-intestinal conditions in relation to pulmonary tuberculosis. Had often felt the need, on his own part, of paying more attention to these conditions. In giving a prognosis in pulmonary tuberculosis, four factors were of especial importance: one, the extent of the pulmonary disease; two, the condition of the gastro-intestinal tract; three, the heart condition; four, the willingness on the part of the patient to obey orders. In marked organic

disease of the stomach, even in incipient tuberculosis, the prognosis was bad. In regard to forced feeding, was in doubt. His practice is to allow patients to rest and then put them on a heavy diet until weight is regained and then to go back to just enough food to hold the patient's weight at that point. Some patients with variable appetites and nausea seem to have a toxæmia. Others have no appetite at all and yet, if urged to eat, will in a few days, especially if out-door life is pursued, be able to overcome this. Dilated stomach is quite frequently met with.

DR. W. W. HITCHCOCK:—Spoke of post-operative (laparotomy) pains in pelvis and their relation to ptosis of abdominal viscera after removal of some viscus. Had gotten good results in these cases from bandage support.

DR. ANDREW STEWART LOBINGIER:—Agreed that operative measures to suspend abdominal viscera had not been as successful in permanent results as had once been hoped for. Operation may, however, in special cases be of benefit. Was his practice after hysterectomies to prescribe a belt for 9 to 12 months, this belt to be made by a corset maker in such manner as to support the lower segment of the abdomen. An ordinary girdle is not sufficient.

DR. F. C. E. MATTISON:—Inquired as to frequency of gall bladder diseases in women with ptosis of abdominal viscera.

DR. BOARDMAN REED:—In closing the discussion, stated that he was pleased with the unanimity of opinion, even though he would have been gratified to have listened to opposing opinions. Agreed with Dr. Black as to complementary relationship of clinical and chemical examinations in gastro-intestinal diseases. And a single chemical examination, especially in neurasthenic states, was by no means sufficient. Every general practitioner should be equipped to make chemical examinations of the stomach contents. Spoke of insufficiency of medical curricula in this respect, of twenty years ago. In 10 years more hopes there will be no need of stomach specialists. Agreed also with Dr. Cole that too much stress might be placed on chemical analysis. His experience showed ptosis of abdominal organs to be about four times as frequent in women as in men. This due largely to faulty dress and especially to the old-fashioned high-up constricting corset, the more modern "straight-front" not being so great a sinner. Childbirth as a causative factor had been over-rated for he had seen a very large number of cases in unmarried young women. Endorsed adhesive support of Rose, but thought it too broad. He, Dr. Reed, used 2 three or four-inch strips, and found they answered the purpose. Removed them at the end of a month or two and then applied for a few days an ordinary girdle bandage until new plaster was applied.

patients a bandage should be worn for 12 months or so. Doubtful if surgery proves too much for these cases of palsy. In four-fifths of his kidney cases, of those which he had referred to prominent Philadelphia surgeons but little permanent good had resulted. Must be remembered that a displaced stomach did not always respond to the plastic treatment. Massage of electricity (strong parallel) very valuable. Special massage movements pushing parts upward during exhalation were

good. Strychnine and other tonics also. Yet plastic treatment better for poor people, since relief was immediate and cost was less. Was glad to note Dr. Pettenger's concurrence in opinions regarding stomach in tuberculosis patients. Stomach condition should certainly receive the patient's and most careful attention. According to Martensen, he had seen no increase in gall bladder diseases in connection with plastic.

## NEUROLOGY AND PSYCHIATRY IN 1905.\*

BY ROSE MOORE, M.D., LOS ANGELES, CAL.

During a three-months' visit in various Eastern medical centers last fall the writer took the opportunity to look up recent advances in neurology and psychiatry. An attempt will be made in this article to set forth the more interesting of the facts thus gathered.

The pendulum swing of medical thought from conservatism to radicalism and from enthusiastic therapy to therapeutic nihilism has rarely been more marked than in the realm of Nervous Diseases. When the great advances in the anatomy and physiology of the nervous system were made during the latter half of the 19th century the treatment of nervous and mental diseases was expected to make a like advance. This was not realized. After a lengthy period, during which one read in the text books that treatment for most nervous diseases was purely symptomatic, there finally has come a change, and today we confidently begin the treatment of many conditions which, but a few years ago, were considered hopeless.

Much of the credit for this change must be given to a small number of surgeons who have made a study of the nervous system and its diseases from a surgical standpoint. The great advance in the use of therapeutic measures other than drugs has also contributed to this change.

Notwithstanding the marvellous refinements of histological technique in-

vented by Cajal and Bethe and others, and faithfully followed by scores of investigators, little has recently been added to our knowledge of *Etiology* by these microscopists. Within the year Ludlum has shown that a thinning out of the fibrils in the nerve cells occurs during experimental exhaustion and starvation of rats. He claims that there is a parallel condition present in the brain of patients dying of general paresis. His opportunities for post-mortem study of such cases is good but his results require to be verified by other investigators.

Probably the most interesting investigation into etiology during 1905 is that reported by Rosanoff in the *Journal* for December. By a series of ingenious and well thought out dietetic experiments based on recent discoveries in proteid metabolism, he was able to show that the actual number of epileptic seizures bears a direct relation to the proteid intake. In other words it is not the kind of food so much as the absolute quantity of proteid which is a dietetic factor in the causation of epileptic seizures. This fact should be of great value in practice, since it is comparatively easy to construct a fairly liberal diet containing the minimum proteid requirement, by reference to one of the many tables showing the composition of the ordinary foodstuffs.

Dr. Harvey Cushing of Baltimore—a man who is blazing new paths in sur-

gery, and especially in the treatment of many conditions not heretofore considered surgical—following Little's lead, has investigated more extensively than the latter ever could, the pathology of infantile spastic and crippled conditions. Speaking in general he avers that birth palsies are generally due to venous hemorrhage from traumatism during hard or protracted labor, and even goes so far as to say that not only the mono and diplegias, but also epilepsy, deafness, blindness and even complete amenia follow in the wake of such hemorrhages. His argument is strong and well proven. The diagnosis of this condition is not ordinarily difficult, being based on the history of the labor, presence of a bulging fontanelle, post-partum asphyxia, convulsions, ocular palsies, pupillary inequality and medulla symptoms such as arrhythmia of pulse or respiration. If in addition to these, lumbar puncture yields a blood stained fluid the diagnosis is plain. Boldly reasoning from his studies on intracranial blood supply and from results of numerous post-mortem findings in the cadavers of the new born and also of persons having some of the conditions named above, Dr. Cushing concluded that with a well verified diagnosis he would be justified in attempting to relieve these traumatic birth hemorrhages by surgical means, this conclusion being allowable only because of the very serious late effects of these lesions and the absolute failure of all other therapeutic means to prevent them. The results reported are encouraging, to say the least. A careful study of an article on this subject in the last October number of the *American Journal of the Medical Sciences* as well as one on the "Special Field of Neurological Surgery" in the last April number of the *Johns Hopkins Hospital Bulletin* will well repay those interested in this subject. The closing paragraph of the former article is as follows: "If it can be demonstrated that a craniotomy on

the new-born child, when conducted with due precaution and delicacy of manipulation, is comparatively free from danger. . . I believe the immediate risk of death and the sorry late consequences of meningeal birth hemorrhages may be avoided in many cases by surgical interference."

Neural surgery is developing in other directions with great promise. In a fair per cent. of cases of poliomyelitis anterior, especially of the arm, the final paralysis is so distributed that nerve anastomoses can be accomplished and by a process of re-education the normal cells can be taught to do double duty, or drive tandem as it were, thus restoring function with preservation of the finer movements—a thing quite impossible by the old method of tendon transplantation. This method is well adapted to the non-cerebral birth palsies also.

It is safe to say that the accepted treatment of major trigeminal neuralgia of years' standing has become surgical, *i. e.*, the removal of the ganglion together with all three nerve roots. In no other way can permanent relief be obtained. With the improved technic devised by Cushing and Lexiner the danger is very greatly reduced and the resulting deformity minimized. The writer was privileged to see three of Cushing's cases during a stay of several weeks in Baltimore. The results in each were all that could be wished, including, as they did, an entire and immediate cessation of pain and relief from the necessity of continuing the use of morphine. The original papers on this subject are of absorbing interest. They are to be found in the *Johns Hopkins Hospital Bulletin* and the *Journal of the American Medical Association*.

Drs. Mills and Frazier of Philadelphia in a series of papers have demonstrated the entire feasibility of operating on cerebellar tumors, providing the diagnosis can be made fairly early. These papers, together with others bearing on different phases of the same subject,



have been gathered together into a neat booklet which is well worth reading.

There has been a rather unusual number of new signs and reflexes described during the past year, most of which, like the one discovered by Oppenheim, are elaborations of others longer known. They are mostly of use in differentiating functional from organic diseases. One of the most interesting of these is described by Graves of St. Louis. It consists of an anesthesia of the nipple areola associated with hyperesthesia which he says is practically pathognomonic of hysteria.

Cytodiagnosis is becoming more or less of a routine practice in many diseases. It is showing itself of value in the differentiation of tabes and general paresis from other central nervous conditions. In the latter diseases a great relative excess of lymphocytes is found in the fluid. The technic of both lumbar puncture and examination of the fluid is not arduous or difficult. It should be attempted much more frequently than it is.

In the province of treatment little is to be added to what has already been said. Exophthalmic goitre has been treated with a new serum from sheep from which the thyroid has been removed. Some measure of success has been reported. Collargolum has been given intravenously for chorea, and in conjunction with bromides to epileptics, with encouraging results. The left lateral position is said to cut short the epileptic attack in the first stage. This is accomplished by cutting off the return flow of blood from the already anemic brain through pressure on the right jugular vein by the omohyoid muscle which is pulled taut by this posture.

A few words will suffice to bring out the changes in our knowledge of psychiatry during the year. There is a very obvious revolt on the part of the psychiatrists against the complete Kraepelinianization of mental diseases as far as classi-

fication is concerned. However, this revolt, when analyzed, is not so formidable as it would at first seem, it being directed against some of the lesser outworks of this remarkable structure, leaving untouched the great central scheme. In this country the group of paranoid forms of dementia precox is not accepted, and heated discussions have occurred as to whether or not Kraepelin means to say that all cases of dementia precox occur on a degenerative basis, or whether he does not admit some which are evidently toxic.

The secret of the immense and growing popularity of the Kraepelin School lies in two facts, first, the remarkable clearness with which Kraepelin has analyzed his cases and presented them to his students, and second, the fact that his is practically the first classification which is based in large part on prognosis. Until an accurate pathological basis is found for all mental diseases, any other convenient method will do. As a result, every writer made his own classification, and psychiatry found itself in "confusion worse confounded." General practitioners, when asked whether the mental patient would regain his mind, were forced to falsify or confess inability to answer, because they were unable to classify and name the type of insanity, and thus did not know the prognosis. Over the horizon of this chaos Kraepelin's classification has risen like a sun, and, by the simple expedient of grouping mental diseases according to their ultimate outcome, has restored us to a semblance of order, making possible a definite prognosis—the *sine qua non* in mental practice.

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We have received the two following monographs by Dr. Charles H. Chetwood of New York City: "Prostatism Without Enlargement of the Prostate; its Diagnosis and Treatment." "Recent Experiences in Kidney Surgery and the Utility of Diagnostic Aids."

**DR. FREDERICA A. KEEP IN EUROPE.\***

We are back from our wanderings and settled for the winter in Berlin. It seems impossible to attempt to tell you of our trip. It was simply perfect from the standpoint of what we anticipated from it in an educational way, and we had such a glorious time!

First, Cologne, with its wonderful old cathedral, the purest type of Gothic in Europe, and the trip up the Rhine to Mayence and on to Heidelberg, the most fascinating of old university towns with a perfect "love" of a castle. But all of this seems so long ago now that I shall never get to the present if I linger over it.

Switzerland was a constant delight, and we all quite lost our hearts to the little sister Republic. Spent several days in Lucerne, and took the trip all about the lake, visiting both the chapels immortalized by the daring deeds of the mythical Tell, who is dear to patriotic Swiss hearts; and from Kussnacht walked across to "Immensee," the scene of Storm's tender German romance. From Lucerne, Harriett, Anna-bel and I started with Mr. and Mrs. Hanson for our walk across the Furka Pass and the Rhone glacier. But it was our one failure! That is, not ours but the weather's, for after one day's delightful tramp with our packs strapped across our shoulders in true Alpine style, through a wildly barren mountain district and across the Teufel's Brucke, our expedition came to an untimely end at Realp, a miserable little mountain village miles from anywhere, where the second deluge seemed to have started. The next morning, the heartless gray flood continuing, we bundled ourselves meekly into coaches and went back to Lucerne and on by train to Interlaken through the beautiful Brunig Pass. Here we

met mother, Nell and John, and after a few days in this popular little resort at the foot of the ever white-robed Jungfrau, went on to Berne. This is a most interesting old town with its fountains dating from the fifteenth century, and covered sidewalks or arcades, as they are called, which were designed 500 years ago and seemed to us then wonderfully old. (That was before our Rome and Pompeii days.) Of course, the old clock with the dancing bears as well as the live bears of the "Bear Garten" had to be visited, for bruin is the heraldic symbol of the Berne canton. We were woefully disappointed in the clock, and think the "marvellous mechanism" of the contrivance is far outranked in our own day and age. The new capital building is very handsome and reminds us in many respects of our own in Washington.

Lausanne and the great vintage festival at Vevey, with a most interesting half day at the old castle of Chillon, occupied the next two days, and then on to Geneva, which mother fell quite in love with, it was so modern, clean, broad-streeted and altogether like a California town with the added attractions of a foreign city as well as an ideal location at the head of the beautiful lake of the same name from which the swift rushing Rhone here emerges.

From Geneva we went up, up, up into the Mt. Blanc region, and entered for the first time France. Here is Chamonix, cool on the hottest of summer days, and with snow-topped Mt. Blanc towering straight up before one seemingly scarce a stone's throw from the town, you could not expect to find it otherwise.

Here began our acquaintance with glaciers, which are numerous throughout this vicinity; great triangular sheets

\*This is part of a letter written to Dr. Nannie C. Dunsmoor. Doctor Keep graduated from the College of Medicine of the University of Southern California in the class of 1900.

of snow and ice, they lie in the mountain side like some great blanket which a mischievous genii has twitched askew and is pulling down to the valley. One of the most exciting days of the whole summer was August 12th, when we crossed the great Mer de Glace, the lake of ice, and climbed down the giddy Mauvais Pas on the other side. Words are helpless things at best, written ones I mean, for you know I swear by my tongue, and I shall not attempt to tell you another thing about it. Just wait until you hear the Keep tongues flying. The picture taken on the glacier looks simply as if we were walking across any snowy stretch, but you see we were not huddled at all, and were really uncomfortably warm in light-weight coats, for the sun was summery although the snow and ice were very real. The next day was Sunday and in the morning we had an earthquake which wrought everybody up fearfully. We thought at first it was an avalanche. Several buildings were cracked, and people, fearing another shake, the congregation did not re-enter the church but stood in the little English churchyard surrounded by tombstones many of which marked the last resting place of those who had lost their lives on the mountains. It was a most picturesque scene. Then we coached half way across the Tete Noire, stopping overnight at Chatalard, a veritable hollow in the hills, and from here some of the party walked the intervening fifteen miles to Martigny, for it was a glorious day and a mile in the Alps seems nothing at all. Then two hours on the train brought us to Brig, and next morning we started that wonderful coaching trip across the Simplon. It is simply impossible to give you even the least idea of the beauty of it. It was wonderful beyond all words, almost beyond all thought. The Grand Canyon of the Colorado is somewhat similar to the Italian side of the pass, but perhaps because we have only whirled through

that on the train this seems to us even more impressive. The broad, beautifully graded roads in these mountain regions, like park driveways at home, are an unending source of amazement to us. Think of bicyclists riding across the Alps. The great tunnel terminus near Domo d'Ossola shows a lavish and, to our American eyes accustomed to steel trestle work, an extravagant use of granite. But I suppose the massive gray rocks, which seem almost priceless because nature must work for centuries to form them, are cheaper in this region than anything else.

Then by train again and steamer in the lake district of Italy, which is surely deserving of all the praise that travelers invariably bestow upon it.

The Milan cathedral, which seems truly to be built by fairy hands, so marvellous is the commingling of intricate detail work in its colossal dimensions, and the light and delicate effect of the whole, and the old abbey church containing da Vinci's "Last Supper," which is so faded and worn that one wonders why they remember and admire it above all copies, were scarcely grasped by our overtaxed minds and eyes before we reached Venice, that "White phantom city whose untrodden streets are rivers, and whose pavements are the shifting shadows of palaces and strips of sky." Venice was a dream, a three-day waking, living dream. We stayed in a pension overlooking St. Mark's square in the old Procuratie Vecchie Palace, which was built in 1480, twelve years before the discovery of America. Of course the Art Galleries, the Doge's Palace, the glass and lace factories had to share our time and admiration with St. Mark's and the fascination of "gondoleering." (I doubt if you will find that word in the most up-to-date lexicon.)

Then came Florence, a perfect treasure house of priceless "chefs d'oeuvre" and places of interest. We had altogether (going and coming) one week there,



and it was not a third long enough. I am now anticipating a second re-reading of "Romolo" with the remembrance of the Loggia where Savanarola was tried, the place where he was burned, the old monastery where he lived, and so much that will make it live.

. . . In trying to read over this letter I realize that I have rushed in rashly on an imperfect itinerary sketch which will tax your forbearance to the utmost. I suppose, however, that I may as well finish and tell you that we simply pronounced Rome the crowning glory of the trip, and if it had not been that we felt the girls should be in a school which would complete their German, we should have stayed there this winter. We "did" as nearly everything that was to be done as an energetic party of eight can in two weeks' time, but two years would not exhaust the resources of the Eternal City.

The whole thing is such a surprise, or was so at least to me. I had always dreamed of Rome as a ruinous old, old place, and had a hazy general notion that all people who didn't live in palaces were sheltered in some way by the ruins of the Forum and Coliseum. Imagine then the contrast afforded by a beautiful modern city, with streets of moderate width, and smoothest of asphalt pavements (those tales of Hawthorne about the cobble-stones of Rome, making all walking a sort of penitential pilgrimage may have been true forty-five years ago but certainly don't hold today,) good electric car service, although cab hire is so cheap that you seem to be fairly earning money whenever you ride, and the people on the streets dressed in so strictly conventional style that you are tempted to believe the *Delineator* dictates to as large a following here as at home, and wonder at your own audacity in appearing upon the streets of such a fin de siècle city with sleeves of a last season's cut. But this is not dwelling upon the magnificence of St. Peter's, the won-

ders of the Vatican collections, nor the beauties of the view from the Pincian Hill, the awe-inspiring mysteriousness of that old pagan temple, the most perfect pagan building now extant in the city, the Pantheon; nor of the hours we spent in the Coliseum reading on the very spot the history of that long-ago time when the gold-fringed purple silk awning was stretched across the great top, and the gayety was highest when most human lives were sacrificed.

We drove along the Appian way and went down into the Catacombs, those endless dark passages which are said to extend over 300 miles in length. Your ticket of admission is the taper you get inside the grounds to carry through the gloomy tunnel, each one assisting the great flaring torch in the hands of the guide. The gloomy impressiveness of it all is perhaps overrated by travelers who delight in magnifying their experiences, as it is nothing particularly uncanny or weird, in fact, I will confess to a bit of disappointment on that score. But there is an undeniable thrill of something closely akin to awe at times as, for instance, when you look upon the cast (the marble is in her church in Rome) of the recumbent figure of St. Cecilia, lying just as her body was found in the sixteenth century. She was martyred about A.D. 280, and, as our guide, an old Franciscan monk, informed us, sang with such ravishing sweetness that the angels in heaven came down to listen or to join their voices with her.

But Rome, the wonderful, the never-ending! That "broadest page of history, crowded so full with memorable events that one obliterates another, as if Time had crossed and recrossed his own records until they grew illegible. How presumptuous it seems to attempt giving you the least idea of it, for there is such an infinitude of history, such a wealth of art, on every hand. I shall

have to fall into poetry and quote Symonds:

"From the very soil of silent Rome  
You shall grow wise, and, walking live  
again

The lives of buried peoples, and become  
A child by right of that eternal home,  
Cradle and grave of empires, on whose  
walls

The sun himself subdued to reverence  
falls."

Naples is only a six hour ride by fast train, and we felt ourselves most fortunate there in seeing Vesuvius decidedly active, in fact, so much so that we did not make the ascent, although we regret now that we did not persuade mother to sanction a tinge of danger, as we should have been practically the last ones up before the earthquake and the eruption which destroyed part of the railway up the mountain.

Pompeii is the most fascinating, to me, of anything in the way of ruins. To think that these things were built before the time of Christ, and were old enough when sealed up for centuries in A.D., 79 to have the stone fountains worn away in hollows where people had leaned to drink. One wall painting shows a surgeon with an up-to-date needle-holder in his hand, at work upon a patient, and there are no signs of change in German sausages of the present day from those painted on the walls of the meat shops. Surely, as Bulwer Lytton says, it points the moral of the maxim "that under the sun there is nothing new." If you want to read a delightful and most accurate book on it get "Pompeii, Its Life and Art," by August Mau, head of the German Archaeological Institute in Rome. It is in the English translation of Francis Kebley.

We were on the Mediterranean Sea the night of the big earthquake in Calabria when so many people lost their lives. We went from Naples to Leghorn by water, and had a delightful twenty-four

hours on the "blue Mediterranean," although we were really disappointed afterwards to think we had not felt the big quake at all.

Pisa is about an hour's ride from Leghorn, but has little of interest except the famous leaning tower which the guide books tell us Galileo availed himself of in making his experiments regarding the velocity of falling bodies, and the Campo Sancto that Ruskin deems "one of the three most precious buildings in Italy."

But how this epistle is stretching out and nothing has been said of the return through the Brenner Pass and the Tyrolean, stopping at Innsbruck and then a week in Munchen, our English Munich, where the Art Galleries are rich reward for a visit; Nurnberg, the quaintly pointed-roofed town where "With a simple reverent heart, lived and labored Albrecht Durer, the Evangelist of Art," as Longfellow so simply and beautifully tells us in his poem "Nuremberg," which, it is acknowledged, may also be taken as a guide to the town:

"Not thy counsels, not thy Kaisers, win  
for thee the world's regard;  
But thy painter Albrecht Durer, and  
Hans Sachs, thy cobbler bard."

Weimar, the home of Goethe and Schiller, was a delightful finish to our trip, bringing us, as it were, back to Deutschland and a generation near our own without the sense of separation from poetry and romance that must necessarily have been ours had we been set down in the midst of this bustling city too suddenly. For Berlin, with its gray skies and soulless immensity, is so overflowing with the self-satisfied egotism of the *Deutschers* that it is not ideal from any point of view. But still we all like it very much, and only hope the winter won't quite freeze the blood in our veins, for they said last winter in Dresden that it was exceptionally mild and I assure you it was then far from balmy.

I have written quite an "enorm," as the Germans say, everything is advertised as "enorm billig" (enormously cheap,) that if I repeat the offense many times—but then there is no likelihood of my having many times quite such a journey to tell you of!

Forgive this long typed epistle, but I found that I was actually submerged when it came to telling my friends anything of our summer. Dear Doctor F. will be interested with you, I know. I think I wrote you last June that we were to return for this winter to Berlin. The girls have entered a splendid school, The Willard, where they are really doing college work and we are all busy, as usual. \* \* \*

Berlin, December 11, 1905.

#### OSLER REFUTED.

Gladstone at the age of 85 translated "Horace."

Darwin wrote "The Power of Movement in Plants" at the age of 71.

Professor Joseph Le Conte was 64 when he gave to the world his mature thoughts on "Evolution."

Field Marshal Oyama was 63 when he invaded Manchuria.

Admiral Farragut was over 60 when the Civil War broke out.

At the age of 77 Senator Hoar wrote and published his "Autobiography of Seventy Years."

Sir Charles Lyell wrote one of his most important works, "The Antiquity of Man," when he was 66. In fact, Lyell's great work on "Geology" was done after he was past 60.

Sir James Paget, the noted English physician, was over 80 when he gave to the world a record of his cases.

Michael Angelo, born 1475, died 1564, was over 60 when he constructed the great dome of St. Peter's.

Goethe was 82 when he finished "Faust."

Mark Twain began life all over again at the age of 64.

Li Hung Chang began life in the rice fields of China, working in water up to his knees from sunrise to sundown. When he had reached the age of 45 we find him worth one million dollars for every year of his life. This he doubled before he died. Li Hung Chang ruled China from his sixtieth year to the end of his life.

Verdi was 70 years old when he wrote his greatest opera, "Aida."

Lord Kelvin (Sir William Thompson) is now over 80. He was head of the Department of Natural Philosophy at the University of Glasgow until he was 72. His strongest and best work was done after he was 60.

Farraday was between 50 and 60 when his most noted discoveries were made.

Jerome, the artist, did most of his great work after he was 60.

Emanuel Kant wrote his "Contest of Faculties" after he had passed his 70th birthday.

Laplace was past 70 years of age when he gave to the world his great "Nebular Hypothesis."

Herbert Spencer at the age of 71 wrote his "Justice" and his "Synthetic Philosophy" was not completed until he was nearly 80.

Baron von Humboldt at the age of 76 finished the crowning work of his life, "The Kosmos."

The great Richard Wagner, who is today perhaps the most popular musical author the world has ever seen, did not produce his famous "Nibelungen Ring" until he was 60, and "Parsifal" appeared several years later.

Haydn produced his oratorio "Creation" after he was 67.

Commodore Vanderbilt made \$80,000,000 after he was 75 years of age.

WINSLOW ANDERSON.



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# SOUTHERN CALIFORNIA PRACTITIONER

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Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

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DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
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## EDITORIAL.

### SUPERSTITION IN MEDICINE.\*

We gain here an idea of the darkness—the depths of darkness—through which the profession of medicine has groped its tortuous way. Thus remedies against warts and corns are quoted as follows: "Lie on your back along a boundary line on the twentieth day of the moon, and extend the hand over the head. With whatever thing you grasp when so doing, rub the warts and they will disappear immediately." And again, "Whoever, when he sees a shooting-star, soon after pours a little vinegar upon the hinge of a door, is sure to be rid of his corns."

The above are some of the prescriptions of Pliny, in the first century of the Christian era. This was the time also of Apollonius, who "cured the lame simply by stroking the affected limbs;

with equal facility he gave sight to the blind—in fact, he even attended to obstetrical cases without fear and trepidation." In one patient who had previously had difficult deliveries—"without even examining the woman for a possible narrow pelvis, or for some other obstacle to birth, he simply advised the husband to procure as soon as possible, a living hare, and, with this hare in his arms, to walk round and round the woman in labor, and then allow the hare to run away."

Astrology has always played an important part in therapeutics. Among some of the teachings handed down from the Babylonia-Assyrian civilization are such as these: "If mercury rises on the fifteenth day of the month, there will be many deaths." "If a planet be pale in opposition to the moon, many lions will die." "If the greater halo surrounds the moon, rain will be visited upon mankind."

\*"Superstition In Medicine" by Prof. Dr. Hugo Magnus, authorized translation from the German, edited by Dr. Julius L. Salinger, late assistant Professor of Clinical Medicine, Jefferson Medical College, etc. Cloth \$1.00. Funk and Wagnalls Company, New York and London, 1905.

Religious relics have likewise played a prominent part in medicine, as witness the following prescriptions: "The most popular was to scrape the tombstones on the graves of the saints as thoroughly as possible. This powder thus obtained was then put into water or wine, and thus a medicine was acquired which possessed an astonishing curative power." "Another very efficacious remedy was the charred wick of the wax candles which had burned in the church. This wick was pulverized and made a powerful curative powder."

Still we do not need to go to the ancients, the early years of the Christian era or the dark ages to find fakirs fattening on credulity and superstition.

"The historian, whatever domain he undertakes to investigate, will always discover that stupidity has at all times been a power superior to all the influences of culture and learning. Mrs. Eddy, with her Christian Science, proves to us that even in this era of scientific enlightenment, this truth remains incontrovertible."

Does the world progress? Take the city of Los Angeles alone! Five hundred fakirs are living off the same human weaknesses that kept Apollonius in opulence 2,000 years ago. Look through the advertising columns of the leading Los Angeles papers. The *Daily Times* of January 28, 1906, contains scores of advertisements similar to the following—"School of Occult Sciences will open training classes for teachers, healers and orators." "Real Roman Gypsy Queen. Take your troubles to Nature's genuine seers, they will truly

aid you." "Madam McKee, Psychic Trance Reader diagnoses disease." "Have an astrologer read your life by the planets. You are at the cross roads. The Occult Seer describes friends, enemies and indicates disease."

We cannot take space to go farther into this subject. It is disheartening. We know of people who have been seriously misled by these charlatans who have led them to make bad investments, to become unjustly suspicious of members of their own family or who have become hypochondriacal and in a constant state of apprehension, all through psychic, astrological and spiritistic "revelations."

Man may be the noblest work of God but he is now, as ever, poor, weak, credulous man.

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#### THE STOMACH IN PULMONARY TUBERCULOSIS.

Dr. Boardman Reed's paper which appears in this issue of the *PRACTITIONER* and which was read at a recent meeting of the Los Angeles County Medical Association, brought out at that gathering a rather interesting discussion in regard to forced feeding in pulmonary tuberculosis. Dr. Reed called attention to the fact, which was emphasized also by Dr. Pottenger, that the probability of cure in pulmonary tuberculosis depended largely upon the condition of the gastro-intestinal tract, the patient having little real chance of recovery if serious stomach abnormalities in structure or function failed to respond to treatment. This point was also emphasized, not so long ago, by an-



other Southern California colleague, Dr. Woods Hutchinson, when he wrote his interesting paper on "Let the Lungs Alone in Pulmonary Tuberculosis." Dr. Viisscher pointed out the danger of putting too much work on the stomachs of these debilitated victims of the great white plague.

The problem is indeed, at times, a hard one to solve. Fortunately, many of the gastric disturbances met with in pulmonary tuberculosis—be they derangements of motility or of function—respond kindly to such measures as the out-door life, proper diet and simple medicinal measures, and while the "alimentation forcee" or "suralimentation" of Débove may seem a rather rigorous therapeutical measure, results in practice seem to continue to warrant its use, no matter what the true explanation in regard thereto may be.

Débove sought to explain the beneficial effects of his treatment in this wise: "The tubercle bacillus develops in a certain soil, a soil which becomes less favorable to its culture when it is modified by *suralimentation* (excess of food); this, indeed, augments combustion, as is shown by the amounts of urea excreted in twenty-four hours—amounts which reach 900 grains, 1,200 grains, and even more. We may also say by this method we give our patients the power to resist their disease; as when the vine is attacked by the phylloxera, one of the best remedies is to manure well the land; by so doing, we do not destroy the parasite, but we give the plant the force necessary to struggle against it."

This explanation while it does not tell us much, sounds plausible and al-

though it is possible that much new light may be shed on these gastric disturbances, as met with in phthisis, we are inclined to believe that an abundance of nutritious assimilable food, eaten at proper intervals in right amounts, will continue to form a part of the treatment of all consumptives, in whom no serious gastric disturbance be present, even though the general weight and strength would hardly seem to warrant so vigorous a course.

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### THE BREADTH OF THE PROFESSION OF MEDICINE.

This caption was the title of a paper by our colleague, Dr. James H. McBride of Pasadena, who made the paper his chairman's address to the Section on Nervous and Mental Diseases of the American Medical Association. It is printed in the *Journal of the A. M. A.* of January 20, 1906, and should be largely read.

A few extracts therefrom are worthy of emphasis, as, "Every physician should be an original investigator; it is one of the obligations of his calling. Medical practice daily offers opportunities for original research." \* \* \*

"The most elaborate equipment for scientific medical investigation is a small affair in comparison to the opportunities of the sick room." \* \* \*

"It is pre-eminently true of nervous and mental diseases that therapeutics is not a thing of drugs only. Aside from seclusion, rest, exercise and hydrotherapy, the future will undoubtedly disclose remedial measures other than drugs, that will be of value." \* \* \*

"Quacks and charlatans have made such prominent and noisy pretense of skill in the way of utilizing the mental life as an aid in treatment that reputable physicians have hesitated to claim any interest or confidence in it."

\* \* \* "It is possible, I admit, with hesitation, that there is a place in medical practice for systematic mental therapeutics, and if proper attention were paid to it, it might result in it being taken out of the hands of mental healers and their like, as the profession took surgery out of the hands of barbers and pretenders."

The excerpts above given are indicative of the general character of the address and bear out what we have already stated, that the article is one that should have a wide perusal.

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#### EDITORIAL NOTES.

Dr. W. W. Roblee has been elected health officer of Riverside.

Dr. C. F. Demsey of Yuma, Arizona, has been visiting in Los Angeles.

Dr. James Kingsbury has removed to Clearwater, Los Angeles County, Cal.

Dr. Joseph E. Blackshaw has located in Hemet.

Dr. John H. Cooper, formerly of Redlands, has located in Long Beach.

Dr. A. J. Scott, formerly of Orange, has located in Los Angeles.

Dr. Dudley Tait addressed the San Bernardino County Medical Society on January 10th.

We have received from F. C. Keck, M.D., San Francisco, a monograph entitled "The Finsen Light."

Dr. C. W. Bryson has been elected dean of the College of Physicians and Surgeons of Los Angeles.

Dr. F. J. Patchin, formerly of Nelson, Neb., has located in Albuquerque, New Mexico.

Dr. Ralph Hagan has been appointed member of the police commission of the city of Los Angeles.

Dr. C. G. Amble of Manzano, New Mexico, was recently called professionally to Albuquerque.

Dr. F. M. Madison has returned to San Diego and resumed his practice in that city.

Dr. O. S. Brown, surgeon of the railroad hospital at Winslow, Arizona, spent Christmas in Southern California.

Dr. F. A. Odermatt of Tucson, Arizona, has returned home from a visit to California.

Dr. J. J. Choate of Los Angeles has been visiting friends in Chihuahua, Mexico.

Drs. Bacon and Koons of Tombstone, Arizona, will attend the county patients for the ensuing year.

Dr. D. W. Dwire of Oxnard has just returned from a four months' visit to the hospitals of Europe.

Dr. F. T. Bicknell of Los Angeles was recently called professionally to Ventura.

Dr. Henry ApJohn of Yuma, Arizona, has been taking a vacation in Los Angeles.

Dr. S. A. Milliken has resigned as county physician at Silver City, New Mexico, and Dr. Geo. K. Angle has been elected as his successor.

Dr. Wm. L. Zuill recently entertained the Pasadena Medical Society at his residence. After the scientific program refreshments were served.

Dr. James D. Eaton of Chihuahua, Mexico, recently spent a few days in Los Angeles. His daughter Dorothy is attending Pomona College.

Dr. Albert W. Moore, of Los Angeles, has been having a long siege of typhoid

fever. His many friends are glad to know that he is able to be out again.

Dr. L. M. Powers, the health officer of Los Angeles, was recently emptied out of an automobile. It was an unexpected pleasure.

The *Boston Medical and Surgical Journal* for Thursday, Jan. 18, 1906, contains a most valuable symposium on tuberculosis and its treatment.

Dr. Samuel A. Ellis of Azusa has been appointed local surgeon for the Santa Fe, covering the territory between Los Angeles and San Bernardino.

"Appendectomy" and "The Value of Work" are two interesting reprints by Dr. Winslow Anderson of San Francisco.

Dr. Clifford Wood, resident surgeon at the Southern Pacific Hospital, Sacramento, was in Los Angeles for a few days a short time ago.

Dr. James Jackson, the pioneer physician of Hemet, has been lecturing at the high school of that city on bacteriology.

Dr. A. G. Haygood, of Downey, Cal., was thrown from his buggy on January 20th and suffered a fractured collar bone and other injuries.

On January 26th funeral services were held over the little son of Dr. B. D. Black, secretary of the New Mexico Board of Health at Las Vegas.

The Montezuma Hotel at Montezuma, New Mexico, is being remodeled and will be used as the National Fraternal Sanatorium for the Tuberculous.

Dr. W. H. Ward has resigned his position as superintendent of the Arizona Insane Asylum at Phoenix. He proposes moving to California.

Dr. J. D. Reed of Covina, Los Angeles county, has been appointed district surgeon for the Southern Pacific Railroad.

We have just received from Dr. Emmet Rixford of San Francisco a mono-

graph entitled "Early Operation in Gallstone Disease."

Dr. Charles P. Thayer, professor of anatomy in Tuft's Medical College, Boston, is spending the winter in Los Angeles.

Dr. Charles Teubner of Saticoy has been appointed the district surgeon of the Southern Pacific Railroad at that place.

Dr. L. Goldschmiedt, who has for some time been practicing at Ensenada, Lower California, has now located in San Diego. The doctor says "it is delightful to be back in God's country again."

Dr. Alfred J. Murrieta, who has been surgeon for the Salt Lake Road at Black Rock, Utah, has recently been appointed to Senator W. A. Clarke's United Verde Mine at Jerome, Arizona. Dr. Murrieta has been visiting friends in Los Angeles.

California lemons are coming in great demand. The juice of the lemon is one of the most valuable articles in many conditions, and the physicians are learning that the California lemon is superior to any other.

Dr. Hiram A. Reid died in Pasadena on Jan. 27, 1906, at the age of seventy-two. He was born at Lisbon, Ohio, in 1834. Dr. Reid was an enthusiastic temperance man, and had done a great deal of work along those lines.

We have received the Annual Report of the Public Library of the City of Los Angeles for the year ending Nov. 30, 1905. The report is most interesting reading and shows the master hand of the librarian, Mr. Charles F. Lummis, the well known author.

The *San Bernardino Sun* of January 6th said that Dr. George B. Rowell of that city was going to move to Los Angeles, but on the next day it reversed itself and said he was going to remain in San Bernardino.



The twenty-third annual meeting of the American Climatological Association will be held at Atlantic City, May 12th and 13th, 1906. Any communications for the Council and Committee of Arrangements should be sent to D. R. G. Curtin, 22 South Eighteenth street, Philadelphia.

The Medical Library and Historical Journal, edited by Albert Tracy Huntington, 1313 Bedford avenue, Brooklyn, New York, is well worthy of the support of the medical profession. The subscription price is \$2 per year.

Dr. D. Gochenauer has been appointed county physician of San Diego county. The doctor's reappointment has come so often that we have lost track of the number of years that he has served. The State Board of Health says that he has the best county hospital in California.

Dr. J. C. Lindsay of Los Angeles was, on July 17, 1905, in an elevator in a building on the corner of First and Broadway when it suddenly dropped, and, aside from the shock and general injury, one leg was fractured. The doctor is now suing the lessees of the building to recover \$20,816.

Dr. George M. Brockway of Florence, Arizona, attempted to make a short cut across the river on December 28th, while on his way to the depot with his family. His horse bogged in the quicksand and the doctor was carried to the shore by a millwright teamster. A rope was procured and the rig and the balance of the family dragged out of a very unpleasant situation.

Balzac in one of his fervent letters to Madam Hanska, says: "My mode of living is now perfectly regular; I rise at midnight, having gone to bed at six in the evening; every three days I take a bath, and I devote fourteen hours to work and two to walking. I plunge in to my ideas and from time to time your

dear head appears like a ray of sunshine."

Apropos of the recent dead-lock between the Mayor and Council of Los Angeles over the complexion of the Board of Public Works, there appeared in an article in the *Los Angeles Times*, the following item, which we are sure, takes a most unfair advantage of the medical staff of the County Hospital:

"Board No. 5 has about as much chance in the Council committee of the whole as a vermiform appendix has in the County Hospital."

The stockholders of the Pomona Valley Hospital Association met in Pomona on January 10th and elected the following for trustees: E. C. Bichowsky, J. Albert Dole, J. F. Lobingier, F. K. Adams and R. K. Pitzer. The report of the president showed that \$8000 was received during the year and most of this amount was disbursed in Pomona. Miss Clara Arbutnot is the matron, and there are five regular nurses.

The *Eclectic Medical Journal*, edited by John King Scudder, A.M., M.D., and published by the Scudder Bros. Co., 1009 Plum street, Cincinnati for \$2.00 per year, is now entering its sixty-sixth year. The appearance of this journal has been greatly improved, and it is certainly very ably representing the school for which it stands. It is a good thing for all of us to keep up on the ideas of this line of medicine. Every number of this journal contains something valuable.

Dr. David E. Francisco, who has held the position of first assistant physician at the Southern California State Hospital for the Insane, tendered his resignation to the board of managers recently, to take effect March 31st. The resignation was accepted by the board, and on the recommendation of Superintendent Dr. A. P. Williamson, it was ordered that Dr. E. Scott Blair, second assistant physician, assume the duties of first assistant and that Dr. Gustave Wilson,

the third assistant, assume the duties of second assistant.

Before the City of Mexico was given a system of sewerage it was one of the most unhealthy cities in the world, but in the years 1901-02 and '03 the great task of draining the city of half a million inhabitants, after 700 years of existence without sanitary measures of any kind, was accomplished. The contract for this great work was let to French contractors. Mexico City is now one of the healthiest cities in the world, being directly connected with the ocean by a drainage canal costing \$15,000,000.

Drs. W. W. Apple, G. W. Burleigh, F. S. Barnard, F. S. Dillingham, J. H. Davisson, Dudley Fulton, O. D. Fitzgerald, E. A. Hanna, W. W. Hitchcock, J. W. Jauch, J. L. Jones, Joseph M. King, Joseph Kurtz, Carl Kurtz, Francis B. Kellogg, Charles D. Lockwood, J. A. McGarry, Granville MacGowan, H. S. Orme, J. J. Still and C. F. Taggart all had their offices damaged by fire in the Douglas Building on January 11th. While the building was not greatly damaged, yet the greatest injury was by water. Several of the doctors had to change their quarters temporarily.

Among the Miscellaneous Items in the current issue of the *PRACTITIONER* is printed a clipping regarding the stand taken by Dr. Stanley Black, Health Officer of Pasadena, in regard to compulsory notification on the part of physicians, of all cases of the great white plague with which they come in contact. His action, to our mind, is to be greatly commended, since we believe that in compulsory registration and fumigation are to be found the most important of all factors, that make for the prevention of the world's great scourge.

A meeting of the Arizona Territorial Board of Medical Examiners was held in Phoenix, January 2nd, and seven ap-

plicants for doctors certificates were given examination. The members of the board in attendance were: Dr. Ancil Martin, Dr. C. H. Jones of Tempe and Dr. Hawley of Mesa City. Those taking the examination were: H. K. Beauchamp, Cave Creek; C. R. K. Swetnam of Prescott; C. D. Jeffries, Bisbee; C. M. Stewart, Winslow; C. L. Standlee, Glendale; F. H. Cartmell, Quartzsite, and J. R. Sutton, Phoenix. Announcement of the results will be made by the board the first of the month.

Mr. Otto Benz, of 137 South Flower street, Los Angeles, writes to the College of Medicine of the University of Southern California:—

"I would like to see the marble statue of Spartacus (breaking his handcuffs and chains) in front of the Barlow Medical Library on Buena Vista street. It should be a copy of the Spartacus of the Italian-Swiss sculptor, Vincerizo Vela. This copy could be made by a California sculptor. Vela made the colossal monument of Columbus and America in Vera Cruz, Mexico. This great piece of statuary represents Columbus with an Indian girl, who represents in allegory young America. The original of the Spartacus of Vela is now in a private collection in St. Petersburg, Russia. A copy of this is in Staefa, a village on the Lake of Zurich. It was made by the Swiss sculptor Siepen by order of the inhabitants of that village in memory of their fight with the inhabitants of the City of Zurich to be freed from the government of the City of Zurich and to have their own village government. In the library building a statue of the goddess of hygiene, with a California girl for the model, would be very appropriate."

Dr. Richard L. Kendall, a physician from Aurora, Illinois, died in San Diego January 3, 1906. He had just arrived in Southern California for his health.

Dr. August F. Lemke, who was recently associated in the practice of medi-

cine with Drs. F. T. Bicknell and John C. Ferbert, died in Pasadena on January 6th. He was highly esteemed by all with whom he came in contact.

Dr. Lemke was born in Ottawa, Ills., thirty-two years ago. After completing his school education he entered the College of Physicians and Surgeons at Chicago, from which institution he graduated in 1895. By a competitive examination he won an appointment as an interne in the Cook County Hospital, where he remained for several years. Subsequently he served as superintendent of the hospital for the insane at Kankakee, Ill., where he remained for two years. From there he returned to Chicago and became associated with Dr. J. B. Murphy and remained with that noted physician for five years. During this time he held an associate professorship in the College of Physicians and Surgeons and was also a member of the attending staff of the Cook County Hospital and the Mercy Hospital. During his college days he was a close associate and room mate of Dr. Craig of Phoenix, Arizona.

Dr. E. A. Hall of Prescott, Arizona, on December 30th brought a mandamus suit against the board of medical examiners of the territory to compel the issuance to him of a certificate to practice. The members of the board are Dr. C. H. Jones of Tempe, Dr. Ancil Martin of Phoenix, Dr. G. E. Manning of Flagstaff, Dr. M. V. Whitmore of Tucson and Dr. Charles F. Hawley of Mesa.

The petition stated that the plaintiff is twenty-seven years of age, and a graduate of the Denver College of Medicine, a department of the University of Denver; that he completed a course in that institution and that a diploma was issued to him. He came to Prescott on July 20 of 1905, and in due time made application to the board of medical examiners for a certificate to practice. His application was accompanied by his diploma and by affidavits from the reputable residents of Rock Springs, Deep-

water county, Wyo. On August 3 he took an examination before the board and correctly answered all questions propounded to him in the subjects of physiology, chemistry, pathology, the practice of surgery, obstetrics and gynecology. It is alleged that the plaintiff moreover demonstrated to the board that he was a fit person to engage in the practice of medicine in this territory, but it is alleged that in spite of this demonstration the board did not issue to him the desired certificate and has not done so yet.

He prays that the court shall make an order requiring the board to endow the examination with results.

The *Los Angeles Times* of January 11th has this to say in regard to Dr. Stapley:

"The aftermath to the elopement of Dr. Walter Stapley, the English army surgeon who was domiciled at San Dimas, Los Angeles County, with Mrs. Sybil Cannon of the same place, came to the surface yesterday in Judge Wilbur's court.

"Despite the fact that Dr. Stapley had wrought havoc in two homes, he began an action for divorce against his wife, Mrs. Mildred Stapley, on the ground of desertion. She came back with a cross complaint charging cruelty and adultery.

"After the affair that set San Dimas and other places by the ears in the early fall of 1904, Mrs. Stapley went to Paris and resumed her art studies that had been interrupted by her marriage. She is said now to have established herself in New York with a reputation as an artist of ability.

"As for Stapley, no one professes to know where he is, and Louis Luckel, his attorney, is not volunteering any information.

"Dr. Stapley and his wife settled down at San Dimas in 1902. They had married at Petermaritzburg, South



Africa, in January, 1898, and both were of pleasing address.

"Stapley soon became intimate with the Cannons. Charles H. Cannon was a wealthy young orchardist of education and refinement, who had married an English widow named Mrs. Mayme. She and Dr. Stapley, both being English, were attracted to one another, with the result that was blazoned abroad about two years ago.

"Cannon was a devoted husband. A torn letter intended by his wife for Dr. Stapley was the immediate cause of the scandal being uncovered. Then there was a scene between Cannon and Stapley.

"After her confession to her husband, Mrs. Cannon threw herself upon his mercy. She implored him to forgive her, and he did. Three weeks later she

joined Stapley in Los Angeles. For several weeks she lived at the Willoughby. Dr. Stapley was a constant visitor, and finally they both registered at the Van Nuys as man and wife. Shortly afterward they took steamer for Australia, and are reputed to be somewhere in New Zealand.

"Cannon was granted his divorce from his wife in December 1904, and now Stapley's application for divorce, with his wife's cross-complaint, is before the court, neither plaintiff or defendant being present. The proceeding is being tried on depositions. Roger S. Page is appearing for Mrs. Stapley. The case was continued for further hearing by Judge Wilbur until the 17th inst. At that time it is probable that some oral testimony will be forthcoming."

## MISCELLANEOUS.

### TEN COMMANDMENTS FOR HEALTH.

A French physician is the author of the following concise and forceful series of admonitions:

1. Rise early, retire early, and fill your day with work.
2. Water and bread maintain life; pure air and sunshine are indispensable to health.
3. Frugality and sobriety form the best elixir of longevity.
4. Cleanliness prevents rust: the best-cared-for machines last the longest.
5. Enough sleep repairs waste and strengthens; too much sleep softens and enfeebles.
6. To be sensibly dressed is to give freedom to one's movements and enough warmth to be protected from sudden changes of temperature.
7. Cleanliness and cheer make a happy home.
8. The mind is refreshed and invigorated by attractions and amusements,

but abuse of them leads to dissipation, and dissipation to vice.

9. Cheerfulness makes love of life, and love of life is half of health. On the contrary, sadness and discouragement hasten old age.

10. Do you gain your living by your intellect? Then do not allow your arms and legs to grow stiff. Do you earn your bread by your pickax? Do not forget to cultivate your mind also.

### DR. W. W. BECKETT.

The following article concerning Dr. W. W. Beckett is taken from the *Conservative Life News*:

"In making up its directorate the Conservative Life Insurance Company has always exercised the greatest care to select men who possess the highest degree of moral character and proved business ability. In Dr. W. W. Beckett is found the embodiment of these qualifications.

"We also find in Dr. Beckett a splendid illustration of what may be accomplished through faithful perseverance. In climbing the ladder of fame the doctor has had to contend with many obstacles, all of which he has surmounted until he stands pre-eminent at the head of his profession.

"Dr. Beckett was born at Forenigrove, Oregon, in 1857. Because of the wild and unsettled condition of the Pacific Slope at that time, the facilities for acquiring an education were very limited, but through perseverance the young man was enabled to secure sufficient education to qualify himself as a teacher. He taught in the public schools of San Luis Obispo, California, for a number of years, and was afterward Deputy Superintendent of Schools at the same place.

"The hum-drum life of a pedagogue did not appeal favorably to young Beckett. He was ambitious to be something more than a country school teacher and decided to take up the study of Medicine. He entered the Cooper Medical College of San Francisco in 1885. After completing a course in this institution, he matriculated at the University of Southern California and graduated with honors from its Medical Department in 1888.

"It was Dr. Beckett's desire to reach the highest point of proficiency in his chosen profession and in order to attain this end he enrolled with the Post Graduate Medical School and Hospital of New York City. Upon the completion of his Post-graduate course he returned to Los Angeles, where he has won much renown as a physician and skillful surgeon.

"Aside from being a Director in the Conservative Life Insurance Company, Dr. Beckett is closely allied with several leading business enterprises and Medical Institutions. He is a Director in the Broadway Bank and Trust Company, one of the founders and Director of the California Hospital in Los Angeles,

and one of the founders of the Idyllwild Mountain Resort in Riverside county, California. He is also a Director in many other institutions which time and space do not permit us to enumerate.

"Dr. Beckett has always been greatly interested in the promotion of education and educational enterprises. He is a Professor of Gynecology in the Medical Department of the University of Southern California. He is also one of the Trustees of the same University and takes a deep interest in its growth and development.

"Dr. Beckett is a man who stands high socially as well as professionally. He is a high degree Mason, a member of the California Club and belongs to several Medical Fraternities. He is ex-President of the Southern California Medical Society, ex-President of the Los Angeles County Medical Society and ex-Vice-President of the California State Medical Society. Wherever known, Dr. Beckett is held in high regard, both for his personal worth and professional skill."

#### COMPULSORY NOTIFICATION OF PULMONARY TUBERCULOSIS.

The following item is clipped from the *Los Angeles Times*:

"Pasadena, Feb. 2.—At the next meeting of the Pasadena branch of the Los Angeles County Medical Association formal notice will be given by the city Health Officer, Dr. Stanley P. Black, that in future, physicians must report all tubercular cases that they are called upon to treat. Dr. Black said yesterday that he will enforce this rule vigorously, and in the event that physicians disregard it, assurance is given that arrests will be made.

"A city ordinance provides that all tubercular cases must be reported to the health authorities, but this ordinance has long been a dead letter. The matter is of importance because it

goes to throw light upon the allegation frequently made that the Pasadena authorities or physicians do little or nothing in the way of a general local supervision of the White Plague, and so lightly has the matter been regarded that doctors have not even gone to the trouble of reporting their cases, in plain disregard of the municipal law.

"It is understood that the Pasadena Associated Charities is willing to co-operate with the health authorities in the matter of exercising some supervision over those who are afflicted with the dread disease, as in the course of the year there are always many cases of poor or indigent people who are afflicted with lung or throat troubles that are brought to the attention of the charitable organizations.

"The remarkable fact was recently brought to light that so comparatively few are the tubercular patients in Pasadena in proportion to the population that the city authorities had not

found it requisite to exercise any stringent regulations, and at that time it was discovered that there was not even an ordinance to properly cover the question of hospitals in residence localities.

"But as a result of the laxity of physicians and the local authorities, persons afflicted with tubercular troubles have not the slightest difficulty in living anywhere in the city or going anywhere. It is probable that if a proper ordinance is adopted and physicians are compelled to report their cases that it would be easy to segregate the worst cases and to exercise some slight but constant supervision over other patients who mix with the public.

"Generally speaking, it is said that the number of cases of persons who are badly afflicted is growing less, though many come here to reside who are but slightly afflicted, or else choose this mild climate as a preventive of the disease."

## SOCIETY TRANSACTIONS.

### LOS ANGELES COUNTY MEDICAL ASSOCIATION.

#### OFFICIAL NOTES.

The Los Angeles County Medical Association meets every Friday evening at eight o'clock in the Art Hall of the Blanchard Building, 233 South Broadway. (Home Phone, Exchange 82.)

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One meeting of each month is designated a clinical evening. Members who can present case reports, specimens or patients for this meeting are urgently requested to notify the Secretary or President.

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Members who have in preparation, papers that would be of interest to the Association, should notify the Secretary or President, so that they may be placed on the programmes.

The officers of the Association to whom communications bearing on their respective work, may be sent, are as follows:

President—Fitch C. E. Mattison, Stowell Building, Pasadena.

Vice Presidents—W. H. Roberts, Frank W. Thomas. W. W. Murphy, Homer O. Bates.

Secretary — Raymond G. Taylor, Bradbury Building, Los Angeles.

Treasurer—John C. Ferbert, Bradbury Building, Los Angeles.

Councilors—E. W. Fleming, W. Jarvis Barlow, C. G. Stivers, W. W. Beckett, Rose T. Bullard, B. F. Church, J. M. King, R. G. Taylor, L. S. Thorpe, F. C. E. Mattison, Frank Garcelon, George L. Cole, Claire W. Murphy, Stanley P. Black.



Trustees—Walter Lindley, J. M. King, R. G. Taylor, F. D. Bullard, J. H. Seymour.

Membership Committee—L. M. Powers, chairman; W. D. Babcock, E. R. Smith.

Medical-Legal Committee—Lewis S. Thorpe, chairman; William M. Lewis, Adelbert Fenyes.

Legal Committee—Albert Seiland, chairman; Frank D. Bullard, Adelbert Fenyes.

Committee on Public Health—W. W. Beckett, George L. Cole, Stanley P. Black.

Pasadena Branch—W. H. Roberts, chairman; J. E. James, clerk.

Pomona Branch—F. Thomas, chairman; G. G. Toland, clerk.

Long Beach Branch—Homer O. Bates, chairman; J. M. Holden, clerk.

Los Angeles Eye, Ear, Nose and Throat Branch—W. W. Murphy, chairman; Hill Hastings, clerk.

#### NEWS ITEMS.

The Council of the Association at its last meeting authorized the formation of an Obstetrical Section of the Society, and invited Dr. M. L. Moore to undertake its organization.

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Physicians who have recently been elected to membership include:

Los Angeles—Charles E. Bacon.

Pasadena—Henry Sherry.

Long Beach—G. C. Brown, C. S. Potter, F. L. Wood.

Monrovia—L. W. Wheeler.

Inglewood—H. A. Putnam.

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Members who have not yet paid their dues (\$5.00) for the year 1906, are requested to do so at their earliest convenience, as the Treasurer is in sad need of funds.

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The January meeting of the Long Beach Medical Society was held in the offices of Drs. Wood & Hamman. A paper on "Heart Tonics" was read and discussed. Dr. F. L. Wood was elected corresponding secretary. At the close of the exercises a collation was served.

The Pomona Valley branch of the Los Angeles County Medical Association met at the home of Dr. F. W. Thomas on the evening of Jan. 12th. Dr. Andrew Stewart Lobingier spoke on "Conditions that Justify the Opening of the Abdominal Cavity for Purposes of Diagnosis and Exploration."

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The Long Beach Medical Society held its regular meeting on January 2nd at the residence of Dr. E. M. Freeman. Dr. J. M. Holden was to have read a paper but was kept away through illness. The evening was spent looking at specimens and in a general discussion.

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The Redlands Medical Society has elected the following officers: President, Dr. G. G. Mosely; Vice-president, Dr. Wm. A. Taltavall; Secretary-Treasurer, Dr. T. C. Pounds.

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The Riverside County Medical Society held its regular session on Monday, January 8th at the home of Dr. H. R. Martin. Officers for the ensuing year were elected as follows: President, Dr. H. R. Martin; vice-president, Dr. Samuel Outwater; secretary, Dr. C. Van-Zwahlenburg. Dr. F. M. Pottenger gave a very instructive address on "The Diagnosis and Treatment of Tuberculosis," and Dr. Wm. B. Sawyer gave a witty and racy paper on "The Substance and the Shadow." Dr. Dudley Tait spoke on "The State Law and its Enforcement." Mrs. Martin invited the guests into the dining room, from whence the fraters adjourned at 2 a.m.

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The New Mexico Medical Society has ceased to exist, and the New Mexico Medical Association has come into being.

#### MEETING OF JANUARY 12, 1906.

The first paper of the evening was an article by DR. THEODORE G. DAVIS, entitled "*A Resume of Recent Literature Relating to the Suprarenal Gland*"

and its Application to Clinical Medicine" containing citations from more than sixty recent authors, of whom a bibliographical list was appended.

Beginning with the work of Bernard in 1856 Dr. Davis hastily reviewed the history, anatomy and histology, stopping only to emphasize the fact that the arrangement of muscle fibres in the large veins and sinusoids acted as sphincters and also by contraction forced the accumulated secretion mixed with blood, into the blood current.

Hetthen suggested the formation of the blood pressure raising substance by the gland cells as being a cleavage of the proteid by enzymic action and further oxidative changes by the aldehyde present, suggesting the tyrosin group of the proteid as the probable source of the substance secreted.

Reviewing the diseased conditions of the adrenal, where tyrosin is not utilized he endeavored to show that lack of function in the gland was followed by pigmentation; dark, even black pigments, being produced from the white substance, tyrosin by the action of enzymes, thus accounting for the melanin and the melanoids which may or may not contain iron, depending on the source of the proteid.

He called attention to the fact that a relation had been shown to exist between vascular hypertension and the amount of indican in the urine, and the possibility of the intestinal mucosa by synthesis, producing blood pressure raising substances from indol and skatol products of intestinal putrefaction and prolonged tryptic digestion and which would point to another group in the proteid molecule, the tryptophan or chromogen group as a possible source of adrenalin.

Taking up the physiological action of adrenalin he showed conclusively that its action was upon the muscle cells directly, and not through the nervous system, which was affected secondarily. That prolonged increase of peri-

pheral resistance and use of pressure meant over-filling of the veins of the minor circulation, with edema of the lungs, and later, by accumulation of blood in the veins of the systemic circulation, of an engorgement of the liver, such as occurs in hypertrophic cirrhosis, and of the kidneys as is seen in parenchymatous nephritis.

Reviewing the work done in experimental laboratories he showed that adrenalin produces changes in the walls of the blood vessels identical with those seen in arterio-capillary fibrosis and atheroma, even to the point of calcification.

Dr. Davis reviewed the recent investigations into the pathology of fibrosis and atheroma by Adami and Klotz and suggested that fibrosis is the result of the production by cellular enzymes, of a substance which causes hyper-nutrition and consequent over production of connective tissue—a true fibrosis. While in atheroma a lipase splits the proteid into fat and fatty acids, which unite with the earthy bases calcium and magnesium to form insoluble soaps. The fatty acids being afterward replaced by carbonic and phosphoric acids, calcification results. These changes instituted by hydrolytic and oxidative enzymes produce variation in the water content of the proteid molecule and give rise to pathologic products such as hyaline, mucinoid and amyloid infiltrations.

Dr. Davis then summarized as follows: Adrenalin has been found to increase the tone of all muscular tissue, mainly by direct action. The vaso-constriction thus produced is manifested, primarily in the splanchnic area, thereby forcing a large amount of fluid into the peripheral vessels, and raising the blood pressure higher than any other known substance. Its action on the vessels of the skin is but slight, its vaso-constricting action on the blood vessels of the brain and lungs is not great, while upon the renal vessels

the constriction is transitory, hence the flow of urine is successively diminished and increased.

The rise of blood pressure, while usually very great, is of short duration. This rise in blood pressure stimulates the vaso-motor center, the heart is quickened for a brief period, then slowed. The pulmonary circulation is engorged by large doses of adrenalin and it lessens the rate of absorption and elimination. Peristalsis is markedly lessened. It acts as a local hemostatic and is useful in peripheral hemorrhage and may be of value for its local action in hemorrhage from the stomach but is of little value in hemorrhage from the lungs, liver or intestines. If given in any large amount it is positively harmful, and especially so if accompanied by infusion of saline solution. It has been advised in uterine fibroma to lessen hemorrhage and good results have been reported from its use in inoperable carcinoma. Here it not only lessens hemorrhage but appears to lessen the size of the tumor by the production of minute extravasations of blood and replacement by inflammatory tissue and subsequent contraction. Its therapeutic indications are two—one as a local hemostatic and two, to raise blood pressure.

No sane therapist would think of using such a powerful agent except when hypo-tension existed, nor would a cautious one use it too freely when atheroma was present in any great degree, especially if the cerebral vessels are involved. Its use in pneumonia, even if hypo-tension does exist would seem unjustifiable in view of the great engorgements of the pulmonary vessels produced by it experimentally, and the same may be said of pulmonary hemorrhage and diseases accompanied by effusion of serum into cavities as in pleurisy and ascites.

Conclusions—The supra-renal gland is essential to life. It furnishes a product which, entering the blood, acts di-

rectly upon the cells, increasing their irritability and contractility. This action is most manifest upon the muscle cells of the heart and peripheral vessels.

It raises arterial tension to a high degree, one, by increasing the force of the heart; two, by increasing peripheral resistance; three, by lessening the elasticity of the arterial walls, (three factors pointed out by Janeway as essential to the production of vascular hypertension), the fourth element, volume of blood in circulation being influenced by the amount of fluids ingested.

If there be continued excess of supra-renal secretion in the blood, changes occur in the vessel walls corresponding to the pathological conditions known as arterio-capillary fibrosis and atheroma, even to the extent of calcification, and I believe we are warranted in concluding that hyper-epinephria is the causative factor in their production. Lastly the essayist called attention to an unrecognized etiological factor in the production of disease of the vascular system, namely—the sexual or procreative function. His attention was directed to this while studying the embryology and histology of the supra-renal glands. Its embryologic source (same as the Wolfian bodies) the arrangement of muscle fibres in the walls of the veins and sinusoids, is suggestive of an erectile tissue and close relation to the generative apparatus, and he knew of no physiological function during which vascular tension is greater than during the sexual act. Excessive venery, then, must be looked upon as an important causative factor of vascular disease. From this view point syphilis is a concomitant disease.

Alcoholism and other intoxications are associated diseases; for the use of intoxicants, in some form, for the purpose of modifying vascular tension, has been common to all people from the earliest ages. That complexus of



symptoms known as neurasthenia has a physical basis in cell exhaustion. In the earlier stages it is accompanied by vascular hypertension, and Federn, of Vienna, states: "All its manifestations disappear where the hypertension is controlled."

Time did not permit the essayist to consider the rational treatment of vascular hypertension by rest, exercise, massage, especially over the cardiac region, warm or hot baths, saline purgatives, especially sodium sulphate or of alkalis which lessen the activity of the supra-renal secretion, or of the thyroid which opposes its action, nor to give a physiological reason for the good effects obtained by the use of iodides or to point out the abuse of nitrites, the hypnotics and narcotics.

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#### DISCUSSION OF DR. DAVIS' PAPER.

DR. JOHN A. COLLIVER:—When asked to discuss Dr. Davis's paper I was requested to illustrate my remarks, as well as the principal points in the paper, with tracings made in some experimental work in the College of Medicine of the University of Southern California.

Experimental research work with adrenalin was at first discouraging. The practical and popular hypodermic method was without results and the apparently impractical intravenous administrations were the only methods possible.

Why did not the hypodermic administration yield results in the normal animal? Before attempting to explain this, it will be well to review the positive action of adrenalin when given intravenously. When a drug is put directly into the circulation its greatest effect will be manifested. Practically all of Crile's extensive researches with this drug were administered this way, and the only positive statements as to the effects of adrenalin are based upon intravenous administration. By examining the tracings which I have taken, you will see:

(1.) Intravenous injection with but one exception, increased blood pressure.

(2.) The rise is sudden and preceded by a latent period of from five to eleven seconds. (Latent period is about the same, regardless of dilution.)

(3.) The increase in blood pressure is from 20 to 65 m. m. of mercury above normal.

(4.) This increase is fleeting, lasting only from 30 seconds to 2 minutes (in one experiment 10 minutes) then swinging back to normal, seldom below like most cardiac stimulants.

(5.) With increase in blood pressure, the heart is generally slowed (in one experiment,

heart rate dropped from 150 to 25 and blood pressure rose 62 m. m. above normal.)

(6.) Large injections per rectum, hot and cold, with low and high dilution, followed by wave curve, return but no marked or mean increase in blood pressure.

(7.) Three large dogs were killed in 2 minutes 45 seconds by intravenous injections of adrenalin, 1 to 1000; heart stopped in systole and respiration continued 45 seconds.

(8.) A continuous high pressure can be maintained by slow intravenous injections of high dilution, 1 to 40,000 or 1 to 64,000.

(9.) The heart is not always slowed with increase of blood pressure. Three experiments showed no change in rate. Five experiments showed increase in rate. There are numerous conclusions one could draw from this data if time permitted.

Hypodermic Use of Adrenalin: The hypodermic administration of adrenalin in 19 experiments produced practically no change in blood pressure or heart rate. This, of course, did not coincide with results I have recorded and observed with the sphygmomanometer in surgical shock.

The most important therapeutical property of this drug is its extraordinary power to contract arterioles or capillaries. This is the secret of its haemostatic use. Why is it not as consistent, then, that when introduced under the skin the same local effect will be produced and cause a contraction of the vessels, thus preventing its absorption? Adrenalin thus produces in normal animals a local ischemia, and absorption is prevented or takes place so slowly that the adrenalin is changed to oxy-adrenalin, which has no blood-raising properties.

In surgical shock we have marked increase in blood pressure following the hypodermic use of adrenalin, because the vascular tone is lost, the arterioles are dilated, blood pressure is slow, blood stream swifter, consequently absorption takes place and constitution effect produced.

In corroboration of this, if administrations of adrenalin is preceded by large dose of nitro-glycerine, then the arterioles are dilated and absorption takes place. This is the same as we find in shock.

In conditions of shock, the administration of adrenalin will raise blood pressure from 30 to 100 m. m. in a few minutes. It is not necessary to combine it with nitro-glycerine, because if the patient is in a condition of shock, the arterioles are already dilated and the drug will be absorbed and its effects produced.

In conclusion, I wish to emphasize:

I. The physiological action of adrenalin is not thoroughly understood. It is true the increased blood pressure is generally accompanied by slowing of heart, but in a number of experiments, there were no changes in rate, while in as many experiments the heart was accelerated. In one experiment the blood pressure was lowered. In three experiments

large dogs were killed in 3 minutes by intravenous injection of 1 to 200 adrenalin. Consequently we must conclude that action of adrenalin somewhat uncertain and at times dangerous.

It is contra-indicated in pulmonary hemorrhage and pneumonia, the greatest effect of adrenalin is upon the muscular coats of the arterioles, contracting them. In the lungs we have little or no muscular coat surrounding arterioles, consequently the supply is not limited to this area. For this reason and for the fact that high systematic tension causes back pressure we find more blood in lungs after administration of adrenalin. Thus its use is contra-indicated in hemorrhage and also in pneumonia, because of the fact that through back pressure more work is thrown upon an already overworked right heart.

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DR. R. C. LEONARD—in a series of between thirty and forty autopsies the suprarenal capsules were made the subject of special investigation. In two cases the pigmentation of the skin was present and the glands showed fibro-casous tuberculosis which could be recognized grossly. After careful study in several other cases where no clinical evidence of Addison's disease was present, the adrenal glands showed microscopic tuberculosis, but it was impossible to recognize the lesion grossly. In these cases the tubercles were typical and showed but slight caseation. In a number of examinations of other cases where sections of the glands showed irregular infiltration of small round cells, serial sections were studied and though no giant cells were found, small areas of caseation in the midst of circumscribed areas of small round cells were present in many sections. It is probable that these were lymphoid tubercles and if thorough search had been made for tubercle bacilli the question might have been definitely settled. This work, even though superficial, indicates that perhaps tuberculosis of the adrenal glands may be much more frequent than one might be led to believe from clinical and gross pathological evidence.

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DR. LYMAN B. STOEKEY—Dr. Davis has stated that the characteristic effect of adrenalin may be obtained in an excised organ, and in an animal whose spinal cord has been severed. Recent experiments are in harmony with this assertion. If, then, epinephrin may produce its characteristic results without the intervention of the nervous system, the conclusion must be that there is a direct action upon the musculature. In other words, the action must be chemical. In light of these facts, two problems of primary importance to the physiologist present themselves, namely: the constitution of this active principle of the internal secretion of the suprarenal gland, and its origin.

In regard to the first question, Dr. Davis has spoken of adrenalin as Methyl Tyrosin—

as Tyrosin plus a  $\text{CH}_3$  radical. This view seems to be prevalent. Now if adrenalin is as closely related to this common end product of proteolysis, tyrosin, as has been indicated, far-reaching conclusions might be justified. In fact, it would be difficult to overestimate the significance of so intimate a relationship between adrenalin and autolytic processes.

But let us examine the evidence upon which this supposed similarity is based. That both tyrosin and epinephrin contain the Benzol nucleus there can be no doubt. That both have in their molecule one atom of nitrogen and three of oxygen has been established conclusively. That adrenalin contains a methyl radical while tyrosin does not is an accepted fact. Now if this  $\text{CH}_3$  radical is subtracted, so to speak, from Abt's formula of epinephrin  $\text{C}_9\text{H}_9\text{NO}_3$  there remains  $\text{C}_8\text{H}_8\text{NO}_3$ , which is the composition of tyrosin. These facts I believe are the chief support of those who maintain that adrenalin is methyl tyrosin.

Now let us look at this question more deeply. All of us know that identity in elementary composition does not mean necessarily identity in constitution. Two substances may have in their molecules the same number of the same atoms and at the same time be widely different. Such bodies are isomers. It is the arrangement of the atoms which is the determining factor. You will ask, then, how does the constitution of tyrosin compare with that of adrenalin? Tyrosin, you recall, is  $\text{C}_6\text{H}_4(\text{OH})\text{CH}_2\text{CH}(\text{NH}_2)\text{COOH}$ , or para-oxy-phenyl-amino-propionic acid. Tyrosin may be broken down, according to the means employed, into para-oxy-benzoic acid, acetic acid, ammonia, para-cresol, para-hydroxymannic acid and oxy-phenyl-acetic acid. On the other hand, as cleavage products adrenalin may yield skatol, pyrrol or pyrocatechic acid. These wide differences in cleavage products are not reconcilable with the view that adrenalin is methyl tyrosin. In fact, these differences alone would show that epinephrin is not methyl tyrosin. Further, adrenalin contains three hydroxyl groups—according to Von Furth and others—and also one methylamino group. This is in decided contrast to the composition of tyrosin. There is considerable evidence that adrenalin is  $\text{C}_9\text{H}_9\text{NO}_3$   $\text{C}_8\text{H}_8\text{NO}_3$   $\text{C}_8\text{H}_8\text{NO}_3$  2. The presence of a methylamino radical might explain the "alkaloidal action" of adrenalin, referred to so often in the literature.

The origin of the active principle of the suprarenal gland is a problem of much interest physiologically. Since autolytic processes can not be looked upon as the source of epinephrin, to what, then, can you will ask, does the active agent owe its origin? In attempting to answer this question I wish to call your attention to an observation made long ago by Vulpian and Arnold, namely, that the chromogen of this gland upon exposure to air, light, or the action of alkalis, is transformed into a substance intimately related to the substance of the gland, producing an increase

in blood pressure. The importance of this finding seems not to have been appreciated, since a relationship between the chromogen and the blood pressure producing substance would have far-reaching significance. All true proteids, it will be recalled, contain a pigment, a proteinochrome, and the most complex processes long have been associated with chromogens. For example, in the vegetable world we know that the chromogen, chlorophyll, is responsible for the synthesis of starch, and that plants which do not contain chlorophyll are not able to build up carbohydrate. The nature of chromogens has been the object of much investigation, and recently, through the researches of Hopkins and Cole, the constitution of protein chromogen has been shown to be  $C_6H_4C.CH_3NH.CCH(NH_2)COOH$ , or skatol-amino-acetic acid. Neucki considered this substance as the mother substance of various animal pigments. Upon heating skatol-amino-acetic acid, or tryptophan, as it also is called, indol and skatol result. Tryptophan also gives the pyrrol reaction. Both of these substances, skatol and pyrrol, it will be recalled, may be had as cleavage products of adrenalin. In other words, tryptophan and adrenalin show a pronounced similarity in regard to their cleavage products—and hence in regard to constitution.

In these facts we have a chemical confirmation of the observation of Vulpian and Arnold that the chromogen of the supra-renal gland is related to the substance of the gland producing an increase in blood pressure.

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DR. F. C. E. MATTISON:—Mentioned a case of hemorrhage of the stomach in which he had used between 2 to 3 ounces of 1-1000 solution of adrenalin chloride, administered per stomach to control hemorrhage, and in which very little effect was noticed upon the pulse. Also mentioned the unusual effects of a hypodermic administration of 10 minims of adrenalin chloride following surgical operations. In both these cases the adrenalin had been administered before the patient left the operating room; they were both severe abdominal operations, the pulse came up very nicely in the use of it. On account of some weakness of the pulse later on, a second dose was given. In both instances the heart beat so hard and full that it fairly shook the bed and was heard at some distance from the bed. Its effects were so alarming that he had been using adrenalin very cautiously since that time, as he felt it is a very powerful heart stimulant and might produce some untoward effects in over stimulating a weak patient.

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DR. T. G. DAVIS:—In closing the discussion and replying to Dr. MacNeil and Dr. Colliver, said: "I cannot conceive of any physiological reason or therapeutic condition in which the use of nitro-glycerine just previous to or in conjunction with adrenalin is justifiable. Adrenalin should not be given except hypotension exists.

## MEETING (CLINICAL) OF JANUARY 19, 1906.

DR. H. P. BARTON of Los Angeles presented specimens of an *Echinococcus Cyst Occluding the Pyloric End of the Stomach*, giving the following facts in regard thereto:

"Mr. S., aged 39 years, stationary engineer. Two or three sisters have died of pulmonary tuberculosis. In 1904 he contracted a severe cold, terminating in a chronic cough, to which he paid little attention until the spring of 1905. In June, 1905, he was suddenly seized with severe colicky pains in the epigastrium. A diagnosis of gastritis was made. In spite of all treatment the pain continued, of varying intensity, for twenty-four to thirty-six hours, when it ceased, and he returned to work, feeling as well as usual. From time to time subsequent to this attack he had transitory pains, which he attributed to gas, and from which he found relief in "dyspepsia tablets." His appetite was always good, and eating or drinking never seemed to cause the pain, but would always aggravate it when it existed.

"His tubercular condition gradually grew worse, and he was finally compelled to cease work, and was advised to go to California. He consulted me concerning his lung trouble soon after arriving here, but did not mention having had stomach trouble. Three days later I was called to see him, and found him suffering intensely with colicky pains in the epigastrium. There was great tenderness over the entire abdomen, and particularly over the stomach. The abdomen was tense and quite tympanitic. Castor oil, Epsom salts and high enemas were given, together with various carminatives. The bowels soon moved freely, the pain and tenderness disappeared, and the following day he was up and around as usual, with a good appetite and normal bowel movements. He gained strength daily for five days, when I was again called and found him in a condition similar to that pre-



viously outlined. The same measures for relief were resorted to, but the result was nil. The stomach was washed out, and various drastic purgatives were given, but no movement of the bowels could be obtained, nor did the pain abate until morphine was given. Temperature normal, or 97 deg. Pulse 120 to 140.

"That the condition was one of paresis, or obstruction was evident; the complete absence of vomiting and hic-cough indicating paresis rather than obstruction. The advisability of an operation was considered, but the man's extreme weakness from his tubercular trouble, and from the twenty-four hours of suffering argued strongly against it. It was now certain that he would die, operation or no operation. The pains ceased, and he sank into a comatose state, and on the third day the patient died.

"The necroscopic examination showed the lungs far advanced in the second stages of tuberculosis. Practically all of the fluids that had been given were found in the much distended stomach. The liver was normal in size, but under the left lobe, attached to the capsule, to the common duct, to the diaphragm; to the pancreas and tissues of the back and to the small intestine at the pyloric junction, was a spherical mass, nearly four inches in diameter, which had completely occluded the lumen of the gut. The difficulty with which it was removed proved the wisdom of our non-operative interference.

"An examination of the tumor showed the characteristic echinococcic cyst, with the common cyst filled with hydatids. I made no microscopical examination of the contents of the cyst, but I am sure that Dr. Black, to whom the specimen was given, will tell you that hooklets in abundance were present.

"I have been unable to determine any positive source of infection. Two years ago the patient owned a pet dog, but

I could not learn the fate of the animal."

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DR. STANLEY P. BLACK presented several specimens of echinococcic cysts and gave the case histories pertaining thereto. One of the specimens was from one of Dr. Sherk's patients. A young unmarried woman of 22, in whom possible pregnancy could be discounted, came to Dr. Sherk with a vague pelvic mass of a somewhat multilocular nature but the exact nature of this mass it was not possible to diagnose prior to operation, at which time a large omental mass containing several cysts was removed, which cysts were found by Dr. Black to be echinococcus. The patient was watched and on the 8th day after operation when the dressings were removed, a mass was made out over the spleen. The next day its outlines were marked on the abdominal wall and two days later when Dr. Black examined the patient with Dr. Sherk, the area of dullness had increased more than an inch beyond Dr. Sherk's original lines. It was then decided to operate and three very large cysts were found in the spleen and were extirpated. The patient made a good recovery and since that time has been in good health and is working.

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DR. C. A. SMALLEY of Los Angeles showed several specimens of a *Metastatic Melano Sarcoma*, the tumor being examined post-mortem by Dr. Stanley Black. The interesting points in the case-history were as follows:

1. The apparent involvement of all the structures in internal capsule without total and permanent hemiplegia and sensory disturbances.

2. The involvement of right Rolandic region without motor symptoms referable to left side.

3. The normal pulse, respiration and temperature throughout disease until very last.

4. The first hemiplegic attack without previous warning and temporarily complete; probably from hemorrhage.

5. The mild subjective symptoms present: The slight headache, the infrequent vomiting, the non disturbance of special senses and the very slight mental disturbance.

6. The metastases involving symmetrically the upper poles of kidneys, and the lungs, liver, heart, spleen and pancreas apparently escaping.

7. The apparent absence of primary growth in accepted sites of such.

8. No apparent systemic disturbance from involvement of adrenals.

9. No symptoms of kidney metastases except an indefinite lumbar pain, not continuous or noticeable until elicited by careful questioning.

10. The almost complete amelioration of symptoms, at times, during period between first attack and last attack, while pathological process continued increasingly active.

11. Finally, the case illustrates forcibly what extreme difficulty one may meet in making an accurate topical diagnosis of brain lesions.

#### DISCUSSION OF DR. SMALLEY'S PAPER.

DR. STANLEY BLACK:—Stated that microscopically the tumors were spindle celled melano sarcomata. He believed the primary growth in this case were in the skin, because metastasis resembled that of sarcoma springing from skin. And that primary growth either in eye or brain would have proved more rapidly fatal, and would have earlier exhibited marked symptoms than in this case. Said there was no clinical way of discovering primary growth in such cases. The microscope should show these to be more alveolar than others. The decided alveolar tumors were the oldest. He did not think growths in kidneys were primary, although he admitted that with increased study of adrenals and their pigment properties, such primary involvement with pigmented sarcoma might be proven.

DR. T. G. DAVIS:—Any disease which affects the functions of the supra-renals may cause pigmentation, whether it be Addison's diseases, sarcoma or carcinoma. Rolleston tells us the supra-renals may be affected by sarcoma either primarily or secondarily, and to the speaker it seemed difficult or impossible to tell whether in this case it was a

primary or secondary affection, although perhaps the point Dr. Black made may point us in the right direction.

DR. E. SWIFT:—Desired to ask Dr. Smalley whether in the case he has just presented he had examined the fundi. Mentioned a case that a few days ago was brought to him by the family physician. This patient gave the history of an accidental discovery of eye involvement. He lay down one evening to read, the gas light being to one side. As he turned his head in a certain direction it appeared to him that the light had gone out. Upon turning his head in the opposite direction and centering his vision upon the light he found it as he had left it. He then began to investigate and discovered that when holding his head in a certain direction in reference to the light he could not see the light. He consulted his physician in reference to this strange phenomenon, who brought him to the speaker. A sarcoma of the choroid of over a month standing was found. It had gone on till there was a detachment of two-thirds of the retina, yet he had only discovered it accidentally. So that here there had existed a gradually increasing blindness, going on until there was vision in only one-third of the eye ground without ocular symptoms being noticed.

DR. ANDREW STEWART LOBINGIER:—Spoke of difficulty in topical diagnosis of brain lesions.

DR. O. O. WITHERBEE:—Said there should be a lookout kept for such cases, and discussed the advisability of removing pigmented moles to prevent primary growth.

DR. C. A. SMALLEY:—In closing the discussion said a careful search had been made for primary lesion, but there were no marks apparent to distinguish the age of one tumor from another. He had not considered a careful examination of eye necessary, since metastasis was already advanced and there certainly was no primary involvement of eye. He admitted there might have been a neuritis, as may occur in tumor of brain. But if that were true it was so slight that its discovery would have been only of academic interest.

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DR. JAMES T. FISHER of Los Angeles presented a *Brain Tumor* specimen, the history of which was as follows: Woman, age 59, about two months before visit, had convulsive seizures of the right foot. No unconsciousness. Convulsions began in the right toe and later involved knee and leg. Finally a right hemiplegia, mild headache, no nausea, eye-grounds showed mild retinitis. Aphasia lasted about 3 weeks. Dr. Lobingier operated upon patient, in first operation

going down to dura, which showed a bulging, and in second operation explored cortex but no tumor could be found. The autopsy three days later showed a hidden growth beneath the cortex, located about one inch posterior to the most posterior portion of the incision.

#### DISCUSSION OF DR. FISHER'S PAPER.

DR. E. SWIFT:—Congratulated Dr. Fisher upon his use of an ophthalmoscope in this case, and expressed the wish that all neurologists would make use of this instrument in all such cases as the one presented. There was one point, however, that the speaker did not understand, and he asked Dr. Fisher whether he meant it when he said he found retinitis, or whether he meant to say neuritis. DR. FISHER replied that a retinitis is what he had found. The speaker went on to say that a simple retinitis was not at all a distinctive feature in brain tumor, though a neuritis, or a neuritis combined with a retinitis—a neuro-retinitis—was distinctive of such a brain lesion, there being a form of neuro-retinitis particularly found in cases of brain tumors. Dr. Fisher then corrected himself and stated that he had intended to say neuritis and not retinitis.

DR. WM. R. MOLONY presented for inspection the specimen and gave the history of "*A Case of Brachial Thrombosis with Subsequent Dry Gangrene of the Hand.*" Patient was a woman, 47 years of age; and had been in average health. She had been living in Leadville, Colo., and was by occupation a Medium and Teacher of Occult Science. She also gave lessons in physical culture.

On Christmas night of 1905, while engaged with her class in physical culture, she felt a sudden sharp pain in her left arm. This pain persisted and became worse during the night. The arm and hand became swollen and discolored and as time went on, seemed to be cold. On Jan. 3, 1906, she arrived in Los Angeles, on which day I saw her. I found her in great pain, with the left hand almost black and greatly swollen. The forearm was swollen, and also discolored. The fingers were mummified. On palpating the arm from the fingers upward I could feel a decided difference

in the temperature of the skin. The brachial artery was hard and thrombotic, a distinct and well defined line of demarcation was present at the wrist joint. She was removed to the California Hospital and Dr. Ferbert and I amputated the forearm about four inches below the elbow joint. On removing the rubber tourniquet there was only a slight oozing in the stump. The radial and ulnar arteries were entirely filled with clot. This oozing presently increased in amount. The arteries of the skin and bones bled fairly free. Dr. F. T. Bicknell who was present, strongly advised, under these circumstances, to amputate at the lower third of the arm, for he said that we did not have enough blood supply to nourish the stump. Dr. Ferbert and I decided to take the chance of saving the elbow joint and sewed up the stump. For the next 5 or 6 days drainage and sloughing was very free, but the stump kept warm and on the 9th day I removed the sutures and found that the skin had healed by first intention: In 2 weeks time the drainage had ceased and the stump was warm and the patient had good action of the elbow joint. I think that we were very fortunate to get union in the presence of such a poor blood supply, but we must not forget that the collateral blood supply around the elbow joint is very good. It is interesting to record that an osteopath who saw the patient in Leadville said that the cause of the trouble was due to a couple of arteries that had become crossed.

Miss Jessie Lawton, the head of the Surgical Department of the California Hospital, who has overseen about 10,000 operations in that Hospital in the past nine years, cannot remember having seen a condition like this, in other words, a case of dry gangrene.

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President Mattison then called upon the members present for reports of cases, the following members responding:



DR. O. O. WITHERBEE:—Reported the case of a boy of eight, who on Christmas day engaged in scuffling with his brothers. The next day came to the city with his mother and complained of fatigue and pain in the right thigh. That night had fever and some nausea. The next day temperature was 103 degrees and pain worse, and the day after there was a higher temperature and delirium. The physician in attendance made a diagnosis of rheumatism. About the second week in January, Dr. Witherbee saw the boy who then had a temperature of 103 degrees and was delirious. Dr. Witherbee made the diagnosis of an infective thrombus in Scarpa's triangle. The leg was oedematous. Operation was performed but found no involvement of vessels in Scarpa's triangle. Abdomen was opened with negative result. Two days later the child died.

Dr. Witherbee asked for diagnoses but none were volunteered.

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DR. GEORGE L. COLE:—Called attention to the prevalence of true Russian Influenza in the city during the last two weeks. One case had come to his knowledge, of a young girl who had had recurrent attacks of appendicitis. In the onset of the influenza attack there were local appendical symptoms and child was sent to hospital but general symptoms led to postponement of intended operation and child went on to recovery with no involvement of appendix.

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DR. STANLEY P. BLACK:—Referred to a man patient who had had enlarged lymphatics of the neck. The larger of these had been removed by operation (tubercular condition suspected but not proven) in Philadelphia. Patient had then been sent to Colorado Springs. Later came to Pasadena. Here Dr. Black saw the patient with Dr. Sherk. The man had a temperature of 103 degrees and physical examination showed glands of neck not enlarged. Spleen

was enlarged and gall bladder was very tender. Liver somewhat enlarged. Pain most when fever was present. Diagnosis of gall-bladder infection made. No operation was performed and patient returned to Philadelphia where Doctors Deaver, Musser and Tyson made a diagnosis of Hodgkin's Disease, which Dr. Black, however, was not quite willing to accept.

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DR. E. M. LAZARD:—Inquired as to the occurrence of typhoid fever through cats. In this connection Dr. Lazard cited the case of a child having typhoid where, after the onset of symptoms in the child, a pet cat had sickened and died with symptoms similar to those of a typhoid infection.

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DR. THEODORE G. DAVIS:—Answered that experiments to inoculate domestic animals with typhoid fever have failed—they die of septicemia. Monkeys have been successfully infected by feeding them cultures of typhoid fever and characteristic symptoms have appeared. At postmortem the lesions characteristic of typhoid fever were found and cultures made from them.

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DR. W. W. BECKETT:—Gave a brief history of gangrene of legs occurring about 10 days after an attack of diphtheria. One leg remained white, but the other leg sloughed. Before death of child, both legs had sloughed at the line of demarkation.

Also made a preliminary report of resection of two thirds of the bladder, for sarcoma in a boy of seven.

#### MEETING OF JANUARY 26, 1906.

The first paper of the evening was read by Dr. F. M. Pottenger, and was entitled "*The Results of Treatment in 94 Cases of Pulmonary Tuberculosis.*"

The essayist stated that pulmonary tuberculosis was a disease that would yield to intelligent, persistent treatment

and that in the treatment it was necessary to individualize, using not only good food and pure air, but to advise judicious rest and exercise, baths and packs, concentrated sunlight, raw meat, inhalations, culture products and serums; in fact, any remedy which reason or experience might have indicated to possess value; good results being greater in proportion as treatment was begun early.

Patients in advanced stages of the disease will respond to natural treatment even though a cure be out of the question. The advanced type of the disease which is most amenable to treatment is the chronic non-febrile form.

Statistics from sanatoria are very interesting even though general conclusions therefrom be somewhat difficult to draw. Of 94 cases treated by the essayist, 52 had been ill from 1 to 5 years. The time of treatment necessary was a difficult matter to forecast but a three months'

period is too short. It may take three years. Complications, such as laryngeal involvement, may lengthen the period considerably. The essayist went strongly on record in favor of the culture products, he having used especially the watery extract of the tubercle bacillus (Von Ruck's) with excellent results.

His observation of institutional treatment showed not only a small number of hemorrhages, but a very general increase in weight. In nearly all cases the best weight of the individual had been regained. The average loss of weight of fifteen of the patients was  $9\frac{1}{4}$  pounds while the average gain for the remaining 79 was  $10\frac{1}{2}$  pounds. Thirty-four (36 per cent) of the patients showed a disappearance of bacilli in the sputum, as a result of treatment. (NOTE. Seventy per cent of the 94 cases were Stage III cases.)

The tables presented by the essayist were very interesting and several of these are here appended.

TABLE OF OFFICE CASES.

Stage	No. of Cases	Ap. Cured	Arrested	Improved	Unimproved	Tuber- culin test	Bacilli		Re- marks
							Ad	Dis	
I	9	8-88.8%	1-12.2%			7	2	0	100% lost bacilli
II	13	7-53.85%	6-46.15%			3	10	4	60% lost bacilli
III	13	1-7.62%	8-61.54%	2-15.38%	2-15.38%		13	10	23% lost bacilli

TABLE OF SANATORIUM CASES.

Stage	No. of Cases	Ap. Cured	Arrested	Improved	Unimproved	Dead	Tuber- culin test	Bacilli		Re- marks
								Ad	Dis	
I	6	5-83.33%	1-16.67%				4	2	1	50% lost bacilli
II	7	6-85.7%	1-14.3%				1	6		100% lost bacilli
III	46	4-8.69%	22-47.83%	15-32.6%	3-6.52%	2-4.35%		46	39	15.22% lost bacilli

**NOTE.** In our classification of cases and results, we have endeavored to follow the report of the Committee on Nomenclature of the National Association for the Study and Prevention of Tuberculosis. We classed these as:

**APPARENTLY CURED.** Where all constitutional symptoms with expectoration and bacilli were absent for three months and the physical signs were those of a healed lesion.

**ARRESTED.** When constitutional signs were absent, and physical signs stationary or retrogressive for a period of two months at least. Expectoration with bacilli either present or absent.

**IMPROVED.** When there was an amelioration of constitutional symptoms, the physical being either improved or unchanged.

**UNIMPROVED.** When essential symptoms had not improved or had increased.

#### DISCUSSION OF DR. POTTENGER'S PAPER.

**DR. J. C. COBB:**—Thought Dr. Pottenger's paper of special value for the additional knowledge it gave of the tuberculin treatment.

\* \* \*

**DR. STANLEY P. BLACK:**—Conservative post-mortem investigations place percentage of human race who at some time or other have had tuberculosis to be about 50 per cent. Radicals say 90 per cent. About 14 per cent. of all deaths due to tuberculosis. Hence great majority of persons undergo spontaneous recoveries. Difficult to define incipient cases, and was skeptical of statistics of results, relating to persons in this stage. Believed sanatoria to be very beneficial. Segregation away from friends, amid hopeful surroundings was very desirable. Does away with homesickness. Believed more in sunlight than in tuberculin. Majority of our California consumptives were unsuitably housed, clothed and fed. Large hotels were not much better. To Dr. Black's mind the real test of successful treatment in pulmonary tuberculosis related to second and third-stage cases. Classification by stages was, however, difficult. Wherever bacilli were present, there were to be found some tubercles, and caseated tubercles were nothing more than small cavities. In this sense, every patient with bacilli was a third-stage patient. In acute forms, might, however, have innumerable non-caseated tubercles with no bacilli present. Prognosis difficult at times. Statistics are fallacious but still we must use them. Felt that sanatoria selected

only the favorable cases. As regards length of treatment, some Eastern physicians seemed to think three to six months sufficient. An Eastern physician should order change of climate for two years at least. When patients return East before that time, they nearly always do worse. As to Dr. Pottenger's tables, these could only be discussed after careful study. Had no personal experience with tuberculin but was willing to believe Dr. Pottenger's statements in that regard.

\* \* \*

**DR. R. WERNIGK:**—Inquired as to resistance of patients where family history was bad. Any relationship to syphilis in remote ancestors? Was there a peculiar type of breathing in tuberculous families?

\* \* \*

**DR. J. C. COBB:**—Asked whether Dr. Pottenger had noted any change in the morphological characteristics of the bacilli which he could ascribe to tuberculin treatment.

\* \* \*

**DR. C. C. BROWNING:**—Took exception to Dr. Black's discussion of incipient cases. Fresh air and sunlight alone, were insufficient. And as to culture products, he was able to speak from his personal experience, since he had used them first on himself; and observation on patients as well as the recorded evidence of a large number of other observers, both at home and abroad, convinced him of their value.

\* \* \*

**DR. F. M. POTTENGER:**—In closing the discussion stated that almost every case reported in the paper had gone beyond the stage mentioned by Dr. Black. Recognized the difficulty of a perfect classification, his cases having been grouped according to Turban's method. What Dr. Black stated about caseating tubercles being cavities he agreed with; in fact, was in the habit of telling all such patients who desired to know if they had cavities, that bacilli in the sputum were signs of cavities even though they were very minute. It was true that many persons infected with tuberculosis go on to spontaneous cure, but the dread nature of the disease forbade taking any chances. Much valuable time, and in the end, money, was lost by patients who failed to carry on the cure systematically. Of early stage cases in sanatoria, his experience had been that about 75 per cent. recovered. Fresh air and good food needed to be reinforced by all rational methods. He believed that tuberculin stimulated the defensive properties of the organism and stimulated also the sluggish conditions to heal. Thus, in tuberculosis of the larynx, in 12 out of his 15 cases, there had been a recovery. This is a much higher percentage than is met with under climatic treatment alone. As to Dr. Wernigk's query concerning heredity, such persons as came of tuberculous stock seemed to have less resistance



than others. Answering, Dr. Cobb stated that he had noted no special change in the morphology of the bacilli as the result of tuberculin treatment.

\* \* \*

The second paper of the evening by DR. E. H. WILEY, entitled "*The Treatment of Minor Surgical Injuries*," with the discussion thereon will appear in a subsequent issue of the PRACTITIONER.

## MEETING OF FEB. 2nd, 1906

DR. BOARDMAN REED of Philadelphia read, by invitation, a paper entitled "*Why We Should Make Thorough Examinations of the Digestive System*," which paper, with the discussion thereon, is printed among the original articles of this issue of the PRACTITIONER.

## BOOK REVIEWS.

A LABORATORY MANUAL OF PHYSIOLOGICAL CHEMISTRY.—By Elbert W. Rockwood, M.D., Ph. D., Professor of Chemistry and Toxicology and Head of the Department of Chemistry in the University of Iowa, etc. Second Edition, Revised and Enlarged. With One Colored Plate and Three Plates of Microscopic Preparations. Large 12 mo. 229 pages, Extra Cloth. Price, \$1.00, net. F. A. DAVIS COMPANY, Publishers, 1914 Cherry Street, Philadelphia, Pa.

While this volume serves well its avowed purpose it is also a valuable book for every practitioner who has not had training in Physiological Chemistry. The carbohydrates, the fats, the proteins, the mucins, fermentation, the saliva, the gastric juice, the pancreatic juice, the blood, the bile, the brain, milk, the urine, urinary sediments are the titles of some of the most important chapters.

CHRISTIANITY AND SEX PROBLEMS.—By Hugh Northcott, M. A. Crown Octavo. 127 pages. Bound in Extra Cloth. Price \$2.00 net. F. A. Davis Company, Publishers, 1914 Cherry Street, Philadelphia, Pa.

In this interesting work there are chapters on "Mixing of Sexes in Schools and Institutions, Battle of Chastity in the Adult, Fornication, Marriage, Modesty, Divorce, Forbidden Degrees, The Sexual in Art, Sexual Perversions and other allied subjects. Plain unmistakable language is used throughout.

DRINK RESTRICTION (Thirst Cures). Particularly in Obesity. By Prof. (Earl) von Noorden and Dr. Hugo Salomon. Cloth, 75

cents. New York, E. B. Treat & Company, 1905.

The author enters fully and entertainingly into the thirst method of treating obesity. This is one volume of the series that Messrs. Treat are publishing on Disorders of Metabolism and Nutrition.

WILLIAMS ON FOOD. Food and Diet in Health and Disease. A Manual for Practitioners of Medicine, Students, Nurses and the Lay Reader. By Robert F. Williams, Professor of Principles and Practice of Medicine in the Medical College of Virginia, Richmond. In one handsome 12mo volume of 371 pages. Cloth, net, \$2.00. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906.

This is an entirely new work and is a convenient and practical book on foods. How they should be used, and giving results and facts and not technical investigations. It is useful to physicians, nurses, and hospital superintendents, and at the same time can be recommended to intelligent families. The book is divided into two parts. Part I. Food in Health. The principles of cooking, and detailed discussions of the different articles of food in common use; with chapters on the proper nourishment of infants, children, adults and the aged. Part II. Food in Disease, shows the variations from the normal diet which are necessary in the more common diseases, and includes a section on the general methods to be observed on feeding the sick.

THE OPERATING ROOM AND THE PATIENT. By Russell S. Fowler, M.D., Sur-

## The Key



to the only sane medical treatment of all those forms of dyspepsia associated with a deficient gastric juice and an enfeebled gastro-intestinal musculature, is found in such remedies as tend, by their stimulative action on the digestive glands and muscles, to re-establish their normal physiological activity.

Colden's Liquid Beef Tonic exerts a specific action on the entire digestive tract. It restores the appetite, increases the quantity and quality of the gastric juice, and normalizes the motility of the gastro-intestinal muscles. Write for sample and literature. Sold by all druggists.

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geon to the German Hospital, Brooklyn, New York. Fully illustrated. Cloth, \$2. Philadelphia and London, W. B. Saunders Company, 1906.

This book is a valuable addition to the literature of nursing. The hospital architect would profit much by having this work for reference. The hospital superintendent, the head nurse and the surgeons themselves will find here an excellent guide.

**BABY INCUBATORS.** A Clinical Study of the Premature Infant, with especial reference to incubator institutions conducted for show purposes. By John Zahorsky, A.B., M.D., Clinical Professor of Pediatrics, Medical Department Washington University, St. Louis. Reprinted from a series of articles in the St. Louis Courier of Medicine, 1905.

Many physicians were interested in the incubators at the St. Louis fair. We all, in our walk down the pike, took in that show, and it was certainly an excel-

lent demonstration of the value of incubators.

This book is the result of Dr. Zahorsky's experience with premature infants in that establishment. It is very valuable and fills a vacant place in medical literature. The author also tells how incubators can be improvised, in the country, for instance, where one of the leading makes cannot be provided. He gives several methods, but the following is one of the simplest:

"Often an incubator can be improvised. Thus, for a recent case, during the cold weather, a box was lined with a blanket, a large opening made on one side, which was exposed to the heat of a steam radiator. Other openings in the upper and lower parts of the box provided for the entrance and exit of air. By placing the box nearer or further





*cine*, by Rolla L. Thomas, M.D., Professor of Practice of Medicine, in the Eclectic Medical Institute, Cincinnati, Ohio.

This work will embrace over 1,000 octavo pages, and will contain two full page lithographs, five full page color prints and fifty illustrations in black. Cloth \$6.00, sheep \$7.00.

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A TEXT-BOOK ON MODERN MATERIA MEDICA AND THERAPEUTICS. By A. A. Stevens, A.M., M.D., Lecturer on Physical Diagnosis, University of Pennsylvania; Professor of Pathology, Woman's Medical College of Philadelphia. Fourth edition, revised. Octavo of 670 pages. Philadelphia and London. W. B. Saunders & Company, 1905. Cloth, \$3.50 net.

Works on *Materia Medica* and Therapeutics will hardly ever lose their charm for practitioners, even though they be at times, the bane of medical students. In Dr. Steven's work, while exactness and comprehensiveness have not been sacrificed to brevity and clearness of expression, the ground has been concisely and systematically covered, by considering the subject under two heads: the first part of the work on *Materia Medica*, giving consideration to the chemical structure, physiologic action, therapeutics and administration of each drug in connection with its respective class; and the second part of the volume, on Applied Therapeutics, presenting the consideration of treatment as applied to the special diseases. Both tasks are well performed. The Fourth Edition of Dr. Steven's work has been thoroughly revised and adapted to the late Revision of the United States Pharmacopoeia.

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ANATOMY, DESCRIPTIVE AND SURGICAL. By Henry Gray, F.R.S., Fellow of the Royal College of Surgeons; Lecturer on Anatomy at St. George's Hospital School, London. Edited by T. Pickering Pick, F.R.C.S., Consulting Surgeon to St. George's Hospital, and to the Victoria Hospital for Children, London, H. M. Inspector of Anatomy in England and Wales, and Robert Howden, M.A., M.B., C.M., Professor of

Anatomy in the University of Durham, Examiner in Anatomy in the Universities of Durham and Edinburgh, and to the Board of Education, South Kensington. New American edition, thoroughly revised and re-edited, with additions. By John Chalmers Da Costa, M.D., Professor of Principles of Surgery and Professor of Clinical Surgery in Jefferson Medical College, Philadelphia, Surgeon to the Philadelphia Hospital, Consulting surgeon to St. Joseph's Hospital. Illustrated with 1132 elaborate engravings. Lea Bros. & Co., Philadelphia and New York, 1905. Cloth; in colors; 1600 pages.

The magnificent *Anatomy* by Gray is too well known to need any extended notice, but this new American edition by Da Costa of Jefferson, adds so much that is new, as compared to editions of several years ago, and through his own mastery of the subject as well as through the liberality of the publishers in the matter of numerous high class illustrations and high grade typographical make-up, presents both the old and the new in such excellent manner as to make special notice thereof desirable. Too many of us are prone to imagine that anatomy is essentially the same today and to-morrow as it was yesterday; and to all such, as it was to ourselves, this new edition of Gray was a great but very pleasant surprise. Practitioners are too apt to purchase only those works bearing on diagnosis and treatment, forgetting that after all, most of what is new in these volumes is based on the later researches in anatomy, physiology and pathology. It is safe to say that if we would consider ourselves up-to-date in our libraries, our anatomy text-books should be of a "vintage" not later than five years ago. Certainly, there is enough that is new, even in the anatomy of the human body, to make this desirable for both our patients and ourselves, and if there be those who are inclined to doubt this, we would ask them to convince themselves by dropping in at one of the bookstores and looking through this new edition of Gray, a work of which the publishing house of Lea Brothers & Company may well be proud.

## THERAPEUTICAL HINTS.

SUNBRIGHTS DEXTRINIZED  
BARLEY JELLY.

Mix to a creamy consistency three heaped teaspoonfuls of Sunbright's Calomedia Food with six teaspoonfuls of cold water. Pour this into fourteen tablespoonfuls of boiling water and boil three minutes; add pinch of salt and flavor to taste. It may be served with sweet cream or a little lemon juice. This is an especially desirable food in typhoid cases.

**SICK ROOM ISOLATION.**—Two sheets are tacked over the doorway—the one on the inside being tacked along the top and down the jamb on the hinged side, while the one on the outside is tacked along the top and down the opposite jamb. This permits the physician and nurse to enter and leave the room without uncovering the doorway, and prevents draughts from blowing the sheets aside. A mixture of one part Platt's Chlorides and four parts of water should be kept in a convenient bowl, so that a whisk-broom may be readily used to sprinkle the sheets and keep them moist. Platt's Chlorides is particularly adapted for the purpose as the Zinc and Calcium Chlorides contained in the combination being deliquescent salts, the moist disinfecting and deodorizing condition of the sheets is more readily maintained than with any other antiseptic solution.

Sal-Heparica is very effective in limiting and reducing the amount of uric acid formed within the circulation and excreted by the kidneys, and is very freely absorbed and taken into the blood and as rapidly (along with the chemical products formed) eliminated by the excretory ducts or organs as is readily demonstrated by its presence, after a brief course thereof in perspiration and urine, the latter more particularly being doubled or trebled as to

quantity and rendered decidedly alkaline.

**DYSMENORRHEA.**—Whether neuralgic, membranous, congestive, inflammatory, obstructive or ovarian in character, responds readily to the pain-relieving and flow-augmenting influences of this product. Ergosapol (Smith) causes the menstrual flow to occur without discomfort and brings the volume and duration to normal limits.

**TREATMENTS OF FELONS.**—Felon's are classed as minor surgery and yet many a finger has been lost through their careless treatment. Antiphlogistine is a specific in incipient cases. Apply hot, change every 6 or 8 hours and resolution will as a rule occur without the formation of pus. If pus has already formed incise deeply and freely. Thoroughness is essential. Evacuate and cleanse with a suitable antiseptic. Insert a drainage tube. Surround the finger with Antiphlogistine. Cut the drainage tube one quarter inch above the surface of the Antiphlogistine. Cover all with absorbent cotton and a bandage. The results will be satisfactory.

The fact stands incontrovertible that antikamnia has proved an excellent and reliable remedy, and when a physician is satisfied with the effects achieved he usually holds fast to the product. That is the secret and mainspring of the antikamnia success. It is antipyretic, analgesic, and anodyne and the dose is from 5 to 10 grains, in powder, tablets or in komicals taken with a swallow of water or wine. When prescribing antikamnia, particularly in combination with other drugs, it is desirable to specify "in komicals," which are rice flour capsules, affording an unequalled vehicle for administering drugs of all kinds.

**CARBUNCLES.**—Creel has relied on echol given internally, in doses of a teaspoonful, in cases of carbuncles, flaxseed poultices applied locally, emptying of pus, scraping out of dead tissue and cleansing with peroxide of hydrogen; after this a topic application of echol on absorbent cotton every four to eight hours. The average duration of this treatment in his cases was ten days.—*Journal of The American Medical Association.*

In the wasting diseases, as well as in rickets, scrofula and marasmus it is of the greatest importance that a remedy be selected which will quickly check the pathological condition, and restore the organism to the normal without producing digestive or other functional disturbances. Cod liver oil has always stood first in the category of remedies calculated to bring about this desirable result, but unfortunately its peculiar odor and taste are features which are quite often objectionable to patients. Hagee's cord. ol. Morrhuae comp. is an elegant preparation, containing all the essential therapeutic properties of cod liver oil and combined with tissue building chemicals (Hypophosphites of Lime and Soda) and aromatics, which renders it agreeable to the palate.—*American Journal of Dermatology.*

Dr. Franklin H. Martin, Professor of Gynecology in the Post-graduate Medical School of Chicago and Surgeon to the Woman's Hospital and the Post-graduate Hospital, says: "I have employed Sulpho-Lythin, and believe it is one of the most efficient remedies for the preparation and after treatment of surgical cases that has recently been brought to light."

Dr. J. A. Herring of Myrtle Springs, Texas, recommends Echol. He says it stops boils and carbuncles.

Gray's Glycerine Tonic Compound lessens cough and relieves bronchial dis-

tress, and facilitates expectoration. It is an elegant preparation, and twenty years' experience with its use has made it the favorite of many physicians.

Dr. E. E. Rowell, Jr., of Stamford, Conn., writes in regard to the treatment of erysipelas as follows: The bowels are first thoroughly acted upon with calomel, followed by a saline purge. For the fever, pain and headache, I give phenalgin and quinine and hourly doses of tincture of veratrum virid. As a tonic and food, I give Bovinine. Locally, the wound is kept constantly saturated with Bovinine pure, the dressings being completely changed three times in twenty-four hours. When I have employed this treatment at the outset, complications have rarely arisen and the course of the condition has been modified and materially shortened.

Dr. B. B. Ralph, of Kansas City, Mo., writes enthusiastically commending Hagee's Cordial of Cod Liver Oil in treating tuberculosis and all wasting diseases.

Dr. W. E. Mack, of Paradise, Cal., recommends Acetozone in quarter grain doses every four hours in a wine-glassful of water as a diuretic in threatened puerperal eclampsia. He says: "I feel encouraged to think if this remedy be used before the onset of the convulsions in eclampsia it might enable the medical attendant to conduct the case to full term without interference."

Pautauberges Solution with creosoted chloro phosphates of lime fulfills the special conditions of dilution and assimilability so necessary in the demonstration of creosote. Nothing could be more logical than to associate lime salts and creosote in an elegant form that allows of their persistent demonstration without risk of gastric intolerance.

Antikamnia and Codeine Tablets are recommended for the relief of sciatic pain. It is claimed that its use in many



cases renders the same service as does morphine, its influence often lasting for as long a period of time and possessing the advantage that it does not disturb the digestive tract nor cause constipation or habit.

Dr. Pitts Edwin Howes, in a recent well known medical journal, comes out strongly in advocacy of the superiority of liquid medicines over alkaloids. "Experimentation," he says, "has demonstrated that liquids are much more promptly absorbed than articles of a semi-fluid or more compact nature. The alkaloids, when you have said the best you can in their favor, are at best only a part of the original plant. We are apt to term them the active principles of the plant. How are we to demonstrate this fact absolutely? Can it be demonstrated? I think not."

#### APPENDICITIS.

Channing W. Barrett, Chicago (*Journal A. M. A.*, April 15), has analyzed the vital statistics of Chicago for the last fourteen years with special reference to appendicitis. He finds that it causes about 1 per cent. of the mortality from all causes. The first consideration is an early diagnosis. All troublesome appendices should be removed without waiting for an acute attack, and all acute cases should be operated on without waiting for pus, rupture, adhesions or a possible interval. Perforation or gangrene with localized abscess should be operated on with drainage or removal of the appendix, according to the judgment of the operator, and operation is the more necessary if there is no walling off of the abscess. Acute appendicitis should be operated on whenever the patient's condition permits, unless he is clearly convalescing. In that case wait till the acute symptoms are over. Healthy appendices should be left alone. The above counsel does not contraindicate rest, stomach lavage or the withholding

of food, any of which measures can be employed as needed with or without operation. Lastly, life is not the only question; time and after-conditions are also important. Adhesions may be temporarily life-saving and later deadly. The waiting treatment favors them. After operation the patient is usually up in from ten days to three weeks. The rest treatment takes a much longer period of time.

#### TYPHOID FEVER.

William Royal Stokes, Baltimore (*Journal A. M. A.*, February 25), has studied the etiology of several epidemics of typhoid. In the first two reported the infection was traced to springs, and in the second of these all other possibilities were fairly excluded. Another epidemic was clearly traced to the milk supply and has already been reported by Fulton. A rather striking fact in this connection was the infection of a number of female factory employes who were supplied a dairy lunch, while the men, not supplied, entirely escaped. A small outbreak which occurred in a suburban community is noteworthy on account of the long periods of incubation, 23 and 28 days in two cases. The last epidemic reported occurred among students in a college and was traced to a student returning from Christmas vacation at home. The sewage was infected from this case and the seepage from the sewer infected the spring. Only those who drank this water took the disease, and the epidemic ceased as soon as its use was discontinued. In all these epidemics the water or the milk supply was thoroughly examined, bacteriologically, and the findings corresponded with the result, the colon bacillus being present in all the infected fluids. The article shows the value of thorough sanitary surveys in typhoid epidemics.





DR. JOSIAH H. PENNIMAN.  
DEAN OF COLLEGE OF LIBERAL ARTS, UNIVERSITY OF PENNSYLVANIA.  
*(Courtesy Alumni Register Univ. of Pa.)*

SEE EDITORIAL.



# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## THE COMMITMENT OF PATIENTS TO HOSPITALS FOR THE INSANE IN CALIFORNIA.\*

BY A. P. WILLIAMSON, M.D., MEDICAL SUPERINTENDENT, SOUTHERN CALIFORNIA  
STATE HOSPITAL, PATTON, CAL.

The Insane are committed to the State Hospitals of California under the provisions of the Political Code. These specify that when a person is found within a city or county so far disordered in mind as to endanger health, person or property, a complaint may be lodged with a magistrate who may thereupon issue a warrant for the arrest of the person. When apprehended the alleged insane person is taken before the Judge of a Superior Court for a hearing. The Judge summons two medical examiners and subpoenas witnesses to give such knowledge as they possess of the acts, words or deeds of the person who is suspected of being insane. The law also provides that certificates shall be made out by the medical examiners containing certain facts. These certificates are made up of a series of interrogatories which, if properly answered, would relate all of the facts required by law. After the hearing, if the medical examiners con-

clude that the person is insane they report to the judge to that effect, who commits the person to a hospital and orders the sheriff to convey the patient to the institution. This is a very brief summary of that part of the Political Code which relates to this subject. The law is certainly explicit and one would suppose that its requirements could be readily complied with by anyone with average intelligence and a moderate amount of industry. Experience, however, teaches that that part of the law which relates to the taking of medical evidence is either ignored entirely or else has so little regard paid to it so that the certificates are valueless as far as imparting information in relation to the development and the exhibition of the symptoms of insanity, although these are the principal facts upon which the verdict is based. In fact, a large number of the certificates which are presented to the hospitals in this state fail to be sufficiently descriptive to even

\*Delivered before the Fourth California State Conference of Charities and Correction, Los Angeles, January 20, 1906.

show that the person committed by them is insane. In defense of this unfortunate condition it may be said that in some cases it is impossible to obtain any information from the patient and that there are no witnesses to testify to the previous condition and to the development of the symptoms, however, this condition of affairs occurs so rarely that it can be practically eliminated from our consideration, but granting that in one half or even two thirds of the cases no information can be obtained from the patient or witnesses, it is certainly reasonable to expect that in the balance of the cases sufficient reliable data may be obtained to detail the history, words and actions of the patient upon which the opinions of the examiners are based. At the present time, if the allegations in the original complaint upon which the patient was apprehended be excluded from the papers, only a small portion of the certificates would contain sufficient information for a diagnosis of insanity. Again it is very strange but a fairly common observation, that these complaints often allege a state of facts to which the certificates do not refer nor can the authorities at the hospital connect the patient in any way with the allegations. The descriptions given by the medical examiners are generally meagre, sometimes incomplete and occasionally inaccurate. The word "unknown" is very much overworked as an explanation why questions are not answered, and "delusion" is also used incorrectly by the mere assertion of the existence of a false mental picture, as if that was sufficient to prove the insanity of a person.

Very few of the certificates which are issued by the courts of this state contain any information from a medical standpoint which is of use to the authorities of the hospital in caring for or treating the patients or as records of the testimony given at the trial of the patient.

Again the manner in which these certificates are filled out show either a failure to exercise the knowledge of insanity possessed by the writers or else a deplorable condition of ignorance of the subject.

The law provides that any physician of reputable character who has been in the practice of medicine for five years may become a medical examiner. Many of the doctors who are thus appointed have had no practical experience with the insane, take no interest in the subject and do not consider themselves capable of making a diagnosis of the varieties of insanity. They, however, accept the position of medical examiner, do the work in the manner to which we have called attention and receive the fee. Some other qualifications than simply practicing medicine for five years should be required before doctors should have the power of sending a man to a hospital for the insane, or of liberating one whose mental state has been questioned, such as, for instance, a knowledge of the symptoms of insanity. One examiner stated to the writer that he knew nothing of insanity, took no interest in the subject whatever, and did not want to be called to Court unless he could examine at least two cases in the same afternoon, because it did not pay. Another physician asserted that he did not know anything about insanity but the judge did and he relied upon the judge to guide him in answering questions. These two physicians simply expressed the opinion of the majority with whom I have conversed on this subject.

The State Hospitals for the Insane do not expect that all of the questions in a commitment paper to be answered in full but the institutions do contend that an attempt should be made to answer questions in such a manner that they shall be intelligible and sufficiently elaborate to describe the mental and physical condition of the patient to

whom they belong. In other words, the certificates should present evidence to prove that the examiners were justified in committing the patient for insanity. In very few instances are the descriptions full enough to give any one a picture of the appearance, actions or words of the patient either prior to his arrest or during his trial. In fact, very few of the committing certificates are descriptive enough to in any way identify the patients by them. There are a number of other weaknesses in the medical certificates which could be pointed out but which time will not permit us to mention. However, we would like to speak of the matter of diagnosis. In many cases the diagnoses are purely arbitrary. We mean to say that there are no symptoms related in the certificate which would justify the diagnosis given and that sometimes, too, the medical symptoms which appear would rather support another form of disease than the one stated and again in some papers the diagnosis of no form of insanity would be justified by the information contained in them. Some examiners seem to lose sight of the fact that these certificates are intended to transmit the testimony obtained in the Court from the patients and from the witnesses summoned.

The general superintendent of hospitals in this state has provided certificates as required by law, upon which insane patients should be committed to the hospitals. If these certificates were used and the questions in them properly and intelligently answered, the result would be a complete record of the patient and the symptoms which he exhibited which led to his apprehension and trial for insanity. Unfortunately these are not in use in the southern portion of the state at all and by only a few counties in the north. False economy leads the various counties to use up their old defective certificates to the great detriment of the patients for

whose welfare they are supposed to provide.

The interrogatories contained in the legal side of the present certificates seem to be generally correctly answered, although from time to time ludicrous errors are contained in them. In one instance the judge's name was inserted in place of the patient.

We appreciate fully that the medical examiners of Southern California are as a rule competent, painstaking and conscientious but through haste or for other reasons they fail in the particulars to which we have called attention.

The object of this paper is not to criticise or find fault with the Courts nor with all the examiners but on the contrary to point out three especial defects in the manner in which the insane are committed. First, that in replying to the questions in the certificates too much haste is exhibited; second, that many of the answers lack accuracy, and third, it is evident that the duties and responsibilities of the medical examiners are not fully appreciated.

As already stated, we have no intention of harshly criticising or finding fault with anybody but we want to direct attention to these several defects which seem to be quite plain, with the hope that the methods in vogue at present may be improved.

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#### DISCUSSION OF DR. WILLIAMSON'S PAPER.

DR. FRED W. HATCH:—The last Legislature passed a law making the appointment of women physicians in the asylums arbitrary and necessary whenever an additional assistant physician was required. July next the money will be available. Each hospital then will be equipped with a woman physician. . . . I might say in this connection that the services of the women physicians have been exceedingly satisfactory.

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DR. H. G. BRAINERD:—Dr. Williamson has given us a statement, it seems to me, indicating a very strange state of affairs, when he tells us that out of twelve papers picked out at random only two of them contain facts enough on which the insanity of the patient who had been committed on them could be



predicated. There is something wrong somewhere when that condition prevails. And it is not alone here in California. . . . Of those adjudged insane in the Los Angeles courts not more than 60 or 70 per cent. at the outside come from their own homes. That will account in a measure for the difficulty in obtaining a history of the case.

There are some other things, however, which I think are stronger reasons than that and it is the method of the commitment of the insane. . . . But the method of the commitment of the insane in the California courts has been a disgrace to this State for years. The same machinery is put into operation that is used to commit a criminal to the penitentiary. Instead of a warrant or information, an information of insanity is sworn out, varying just in form, and that is all. It is put in the hands of the sheriff, and the man is arrested. He is taken to the county jail, but by a recent arrangement he is placed in the care of the deputy sheriff at the county hospital, which is a little improvement. He then is brought into court and is confronted, as any other prisoner would be, or arraigned, as any prisoner accused of crime, and he is examined in open court, the only difference being that there are one or two or three physicians appointed by the court acting as prosecuting attorney and jury combined, while in the other case the criminal is prosecuting attorney and is tried by a jury of his peers. Then he is committed to the hands of the sheriff. He is committed to the asylum as a criminal is committed to the penitentiary, and when he gets to the asylum, then for the first time he receives the treatment of a sick man and not of a criminal. Now, it is not the fault of the courts so much, under these conditions; it is the difficulty of getting evidence in open court in regard to the strange actions of the person whose case is under consideration. . . . We find it especially difficult to get the testimony of children against parents. I say "against," because that is the term which is used by the law. And it is difficult to get the testimony of the wife against the husband or the husband against the wife. It is very difficult. . . . I believe that the fault that Dr. Williamson rightly complains of is due to our methods and not so much to the fault of the individual examiner. It is true that many examiners simply go there for the sake of making the fee, but take the large proportion. If they had a suitable law and a suitable method for making the inquiry, I think there would be but little difficulty in getting at least some sort of a history that would enable the superintendent of the hospital to say, "Why, this man is certainly insane, from the history which he brings."

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DR. KING, Superintendent Utah State Hospital:—This is a subject of considerable importance. Lately there has come to my

knowledge in several ways that this question of the proper commitment of people to the State hospitals is one that is liable to give us a good deal of trouble. We have had at our hospital within the last three months, I think, three or four different applications for writs of habeas corpus. . . . Now, it may be possible, with the law we have at present, that the law requires that the patient should be brought into court. Under our Constitution perhaps that is correct. But this decision by the Supreme Court was not based so much upon the Constitution as it was upon the common law, that a man had a right to be free and could not be deprived of his liberty without due process of law, and that due process of law was defined in a certain way. Dr. Williamson has evidently stated, very mildly perhaps, the condition of our commitments. The information which we get in these commitments, as he has stated, in a great many cases does not give us such facts upon which we can base the evidence of insanity. We have to find that out after the patient is brought to the hospital. I went over, recently, the commitments that were sent to our hospital for the last six months. In some instances we get sufficient information, but in a large proportion of the cases we do not get that information, and in some instances we simply have got the name of the patient, and no information except the word, written along the pages of the commitment, "Unknown." Simply the word "unknown." Now, we receive those cases simply because they are committed by the courts properly, and then we have to commence getting the information ourselves.

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DR. STONE, Napa State Hospital:—In reference to the matter under discussion, I want to indicate what Dr. Brainerd has said with reference to the commitment of patients. I think that the fault does not lie entirely with the medical examiner in the large cities, because the patients who are brought to our institutions from large cities are generally strangers in the community. Therefore it is impossible to get the evidence from the patient, and having no relatives or friends in the community, the blank comes to us, the commitment blank, with the questions answered in that indefinite way. In the small communities, the outlying districts and in the country, I think our commitment papers are better, because the people who are taken from these localities are people who have resided in the community for a great many years, and the family is well known. The diagnosis on our commitments at Napa from San Francisco are generally left blank. The examiners there do not pretend to make a diagnosis—they leave that matter entirely to us at the hospital. There are often patients committed to our institution from large cities—I know this from experience in the hospital at Napa, from

say, San Francisco—where patients are frequently committed who should never be sent to the institution, and that is due largely to the fault of the examiners in being hasty. They are those cases where the examiners have had no opportunity to investigate. Frequently they take the word of some member of the family or some immediate friend, or the physician who has had charge of the case for a short time.

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DR. J. K. M'LEAN:—Might we hear from some one of the visiting superintendents as to the desirability or undesirability of having the patient conveyed from the court to the hospital by an officer of the law rather than some person deputed from the hospital to go and convey him there?

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DR. STOCKING, Agnew State Hospital:— . . . There is great jealousy and great feeling that people are often railroaded to hospitals, and therefore provision must be made also that a person who is not insane is not unjustly sent to a hospital for the insane. Therefore these two conditions must be met, and while the physicians might be capable, and should be, and they are the ones that should determine the matter of the mental condition of the patient and whether or not it is advisable to send him to a hospital for the insane, yet at the same time the lawyer thinks that also he must be protected in his rights, and, as said before, against being railroaded to a hospital. And here I may say parenthetically, that I have been connected with hospitals for the insane a great many years, and there have come before me several thousand patients, and I have never seen one yet that was railroaded to a hospital. . . . But, as I understand, Dr. Williamson's paper is not questioning the laws so much, or finding fault with the method of committing so much, as it is finding fault with the methods. . . . It is desirable for the physician at the hospital to have as complete a history, not only of the patient and his case as relates to his insanity, but of all his life and the life of his ancestors, just as far back as it is possible to obtain it. This is useful in making a diagnosis, in making a prognosis, and in the treatment of the case. And it is so that many of the commitments show inexcusable carelessness on the part of the committing physicians. Very often, perhaps, they could not obtain the information, but there is too much evidence in the commitments themselves that they have not made an effort to obtain the necessary information, which would be so desirable. I think the judges might aid in this matter by insisting that the physicians do obtain more information, and that they give us more information. Strange as it may seem, in the largest cities there is the greater fault. The physicians that are called most frequently are often most at fault.

They get careless, they get hasty, they don't take the time to give us the information that they ought to in regard to those things.

Now, with regard to the conveying of patients to the hospital . . . It would be entirely practicable and would be far better to permit the hospitals to send for the patients. Let them be committed, and then allow the hospital to keep in reserve a certain number, whatever is necessary, of men and women who are trained in the caring for and handling of insane people, who can be sent for the patient when the hospital is notified that the patient is ready to come to the hospital. (Applause.) It is entirely practicable; it can be done, and is being done in some other States. I will tell you where we should have some trouble about having it done here. It is going to put a little more work on to the hospitals. It would not increase the expense to the state, but it would diminish the expense of the state. It can be done by the hospitals cheaper to the state than it is done by the sheriff's office, but it would take away from the sheriff's office some of the revenue and some patronage. Therefore the sheriffs are not in favor of it. But I think it is a good question to bring up before you people, because whether or not it shall be done does not depend so much upon the officials of the hospitals. We can present it, and advise it; we can advocate it, but after all the people must want it and say they want it and will have it that way, and then they can have it that way. Time and again, for instance, I have seen a patient come into the hospital with at least two deputies, great, big, stalwart men, and even then perhaps in restraint, in full restraint. It is very seldom that an insane man, a candidate for a hospital, cannot be brought to the hospital by one attendant, without any restraint, if the attendant is one who is skilled in the management of the insane. And I have seen women brought with perhaps two men and one woman as deputies, and still in restraint, with wristlets or even perhaps strapped down, because that was the easiest way to manage them—to put them into a baggage car. These patients come to us; we immediately free them from restraint; they are given the necessary freedom to go about, and perhaps we never have any trouble with them. It is a matter of handling. That I think, is a very important matter, and would be a very great step forward if the people of California would come to do that, and we would appreciate it and it would be a great blessing to these unfortunate people.

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DR. HATCH:—Mr. Chairman, in the last year, the year ending June 30th last, there were, you know, something over 150 commitments of people who had been in the state less than one year. Of that number a little over half of them were committed to the Southern California State Hospital, in the southern part of the state. The last legis-



lature passed a law requiring a year's residence in this state to permit one to be committed or to be dated for in our state hospitals, leaving it to the commission in lunacy and the superintendent to determine whether or not it was humane and proper to return that patient to his own home state. There are difficulties in the way of putting that law into active execution. In the first place, a man leaving, we will say, Colorado, for California, leaving in fair health and apparently sane, arrives here, and two months afterwards gets into an asylum. We take up the proposition of his return with the Attorney-General of Colorado. He says, "We have a law putting our own people in our asylums, but we have no law for putting our people who have gone to California in our asylums. You will have to show me," he says, "that this man was insane before he left Colorado." In other words, that he could not have an intention to reside. He founds it on the question of intent, that if the man left Colorado for California with the purpose of becoming a resident here, and had mind enough to conceive that purpose, that that man is a resident of California the moment he gets here, and they will not take him back. Well, of course, we have to have a little cooperation to make this thing work. We cannot take a man from Colorado and turn him out on the streets, and we cannot force them absolutely to take him back. There has got to be a little cooperation between the states. There has got to be a little reciprocity in the thing. We send quite a number back to their relatives, and occasionally we get a state to take one back. We have to take them back; we have taken them back from Michigan, from Wisconsin, but the great point is the question of intent. They base the residence on the intent of the person.

One or two other questions I might speak of now that I am up, regarding commitments. One of the ideas of the lunacy law and the commitment which was created by that commission was to make the examination at the alleged insane man a medical process, and less a legal one. It was made quite thorough regarding the medical examination, and for about three years we had plain sailing, but then the legal side of it came in for criticism. It was declared unconstitutional. We have had perhaps forty or fifty taken out on writs of habeas corpus, who were committed under that commitment, the main reason being that the patient was not notified in advance, or what he was being examined or tried for, and that he must have previous notice. That was the basis of the thing being declared unconstitutional. In the commitment of every person there must be a legal and a medical side. If you will consider the thing for a moment, what does it mean? It means sequestration, separation from home, friends, family—civil incapacity. Sequestration for an indefinite period. You have got to have a

legal process that protects the man or the family and the public. You cannot do away with the legal forms. The only proposition about it is that if people would examine both sides, and physicians will realize the seriousness of the proposition, the fact that it does mean sequestration—when a man is sent to the jail for six months he knows when he is going to get out, but when a man comes to the hospital for the insane he knows nothing as to when he is going to come out, if ever. You cannot tell. Of course, he is not there for punishment—he is sent there for the benefit of himself and for the benefit of the public, but it does mean an indefinite withdrawal from everything that the man has hoped and lived for, and if judges and doctors will look at it from that point of view and realize that every bit of information that carries us back into the man's history that shows us the origin of this thing, is of importance, they will be more careful. The question of diagnosis amounts to nothing. You cannot expect two physicians, who see a man for an hour or an hour and a half to twenty-four hours, to make a diagnosis, when it takes the hospital physician, who is working in that line all the time, maybe two or three months to make it. You cannot expect it, and they had better leave that blank and put their time in in giving us the information.

Now, regarding the transportation of patients by the sheriff's offices. In Washington and Oregon within the last year the law has been changed, taking it out of the hands of the sheriffs and putting it into the hands of the hospital. It is very much more satisfactory, both from an economical standard and from a humane standpoint. It is safe to say they save about 50 per cent. in expense. The patients naturally are better cared for. We have tried in this State to accomplish the same end, but when you got up against a bunch of sheriffs from every county in this State, who are well organized, you will be against a pretty hard proposition. They have fought it before, and they will fight it again, probably, unless we proceed as Oregon proceeded. They cut the fees and the expenses down so low that there was nothing in it for the sheriff, and he threw up his hands and said, "Take it." (Applause and laughter.)

### CHANNING'S SYMPHONY.

"To live content with small means,  
to seek elegance rather than luxury,  
and refinement rather than fashion; to be  
worthy, not respectable and wealthy,  
not rich; to study hard, think quietly,  
talk gently, act frankly, to listen to stars  
and birds, to babes and sages, with open  
heart; to bear all cheerfully; do all  
bravely, await occasions, hurry never;  
in a word to let the spiritual, unbidden  
and unconscious grow, up through the  
common; this is my symphony.—William Henry Channing.



**TREATMENT OF MINOR SURGICAL INJURIES.\***

BY EDWIN H. WILEY, LOS ANGELES, CAL.

Those diseases and injuries for whose relief important surgical interference is indicated, are widely discussed and their treatment familiar, in theory at least, to nearly all of the medical profession.

There is a class of injuries, minor in importance, which by far out-numbers the major operations, and which frequently does not receive the same intelligent treatment accorded other branches of surgery. There are several reasons for this. Occurring as they do in the course of the patient's daily occupation, they are hurried to the nearest medical man. He, frequently, is one who is unfamiliar with practical surgical technique or is unprepared to carry it out at the office. The injury is not one which endangers life and the pernicious effects of sepsis, so likely to follow perfunctory attention, are lost sight of. This tendency to slight thorough surgical treatment is ably seconded by the patient's request for a plaster and his fear of sutures.

The field is dirty as is the wound itself and too frequently are such wounds looked upon as predestined to suppuration by the very nature of the injury. Hence no effort is made, or at best but a half hearted one, to secure primary union.

The injuries most frequently met with concern themselves, naturally, with those portions of the body most exposed to traumatism, namely, the head and extremities.

In the first named locality, the hairy scalp is most often the seat of injury. Trauma ranges from abrasions to interruptions of continuity which often lay bare the skull, and from simple incised to severely lacerated and contused wounds. Falls upon the vertex and violence by blunt and sharp instruments in the same situation, alike result in more

or less linear defects, the rounded skull serving to split the scalp even when brought into contact with a plane surface.

Several local peculiarities of anatomical structure in this situation are worthy of mention. The hair follicles extend through the entire thickness of the cutaneous layer and enter into the superficial fascia which constitutes the second layer. Beneath this is the strong aponeurosis of the occipito frontalis. More deeply is a layer of loose areolar tissue containing fat, blood vessels and lymphatics. Covering the bone is the pericranium, analagous to the periosteum of the bones.

Injuries superficial to the aponeurosis of the occipito frontalis are less dangerous than those below, because infection beneath this layer may burrow under the entire scalp without finding an outlet. Also by extension through the emissary veins or at the sutures, where the periosteum is continuous through the suture line to the interior, infectious agents may cause meningitis and sinus thrombosis.

Wounds transverse to the aponeurotic fibres gape widely, while those parallel to their length gape little or none. The edge of the divided fascia to the palpating finger sometimes gives the impression that a skull fracture is present, and only good illumination of the wound dispels this impression. It may even be necessary to divide with a scalpel the pericranium to settle the question definitely.

Loss of substance from the pericranium almost never results in necrosis of the bone because the skull receives from within the diploic layer nutrition sufficient to maintain vitality.

The blood supply of the scalp, entering from the periphery and extending

\*Read before the Los Angeles County Medical Association, on January 26, 1906.

toward the vertex, insures sufficient nourishment even when flaps have been found. Its abundance also insures favorable results under cleanly technique, even in the presence of contusion and laceration.

Injuries to the extremities occur in the hands more often, and less frequently in the feet and legs. The anatomical structure of these members is very similar with the notable exception that the blood supply of the lower extremity is poorer or the venous return flow more sluggish; hence the proportionately greater danger of necrosis and infection.

In these members we have to deal with more delicate and complicated structure, tendons and their sheaths, synovial membranes, important vessels and nerves, all of which are superficial, overlying bony structures, against which they may be crushed or torn by the injuring force, if they escape its direct effect.

The principles underlying the treatment of these injuries differ in no wise from those governing other surgical fields. Of these the first and most important is surgical cleanliness, which includes the removal of hair, dirt and foreign bodies from the wound itself and from its immediate neighborhood, and the application of such antiseptic solutions as tend to destroy or inhibit the growth of those micro-organisms which cannot be removed by mechanical cleansing.

The greatest difficulty in the application of this principle arises from the fact that the necessary maneuvers cause the patient more pain than he is able or willing to endure, and the injury is not severe enough to justify the administration of a general anaesthetic with its elements of danger and subsequent distress.

This leaves us then the alternative of local anaesthesia, which may be produced by various means. Of these, none

compare in thoroughness and efficiency with the infiltration method of Schleich.

Its application causes little pain, the anaesthesia is complete and lasts long enough for all necessary maneuvers. By substituting Beta Eucaïne for the cocaine of the original solution, all danger of infection is avoided as the solution may be boiled without impairing its efficiency. Lastly it can be used in sufficient quantity to produce the necessary anaesthesia without fear of constitutional symptoms from absorption. The addition to it of a solution of adrenalin chloride produces better the anaesthesia desired, at the same time minimizing the oozing from torn vessels.

Having then shaved a large area surrounding the wound, the area is cleansed with soap, water and brush, aided in case of grease by a solvent such as benzine. During the process the wound should be protected by a gauze sponge to prevent its further contamination.

The surface having been cleansed with 1 to 1000 solution of bichloride of mercury the infiltration is begun, using a medium size aspirating syringe, and carried on until the entire area involved is numb. In very painful areas or with nervous patients, the infiltration may be commenced before the scrubbing with little danger of infecting the field.

The operator, under the usual aseptic precautions, now proceeds with good illumination, to spread open the wound, exposing any pockets or recesses, and with forceps and sponges removes hair, dirt and blood clots. Any bleeding vessels must be caught and if oozing is marked, pressure with sponges wrung out in hot bichloride or salt solution kept up until it is checked.

If the wound is large and many particles are ground into it, a sterile brush with green soap and boiled water vigorously applied will remove the dirt most quickly.

With scissors and tissue forceps any tags of tissue whose nutrition is doubt-

ful should be cut away, as well as the masses of fat which often obtrude upon the field. If minute particles are so ground into the wound as to render their removal impossible, the tissue containing them is best trimmed away with scissors by holding them nearly parallel to the tissue plane and cutting on the flat.

All visible contamination having been trimmed away, together with fat and tags of tissue, the wound is swabbed and flushed with quantities of bichloride solution and may reasonably be treated as a clean one ready for closure, after application of the second principle, namely, haemostasis.

Occasionally a vessel is torn whose size demands ligation. The smaller ones usually yield to twisting or hot compresses. Under no circumstances should a wound of this nature be closed until the hemorrhage is completely under control. Blood clot furnishes an ideal culture medium for the development of bacteria.

A third important consideration is obliteration of dead spaces whose presence favors retained secretions with liability to subsequent infection and prevents rapid union of tissue.

Lastly the closure should approximate tissues of a like nature and the part with suitable dressings applied be put at rest.

In regard to the dressing, the whole assumption being that the wound is now a clean one, a dry dressing is the logical sequence and such a one should be applied and maintained unless subsequent events fail to justify the assumption of wound sterility.

Each case calls for individual judgment in its treatment. Suture materials, antiseptic solutions and other details of technique, must vary with the preference of the individual, but the basic principles remain the same.

There is no class of work which yields more pleasing results with proper attention and none in which careless-

ness results in more pain, temporary disability and danger of sepsis to the patient. The element of time is an important one, as the majority of the victims of such minor injuries depend for their livelihood upon their daily manual labor.

Particularly on the hand large scars are undesirable, both for the cosmetic effect and from the limitation of function which results from their shrinkage.

This plan of treatment is applicable obviously only to recent wounds which have happened immediately before or which have come for treatment within a very few hours. Fortunately the larger number are seen immediately upon the receipt of the injury. After absorption has taken place and the lymphatic channels in the neighborhood are filled with infectious materials, it is unreasonable to hope to render the wound clean and to close it with the expectation of obtaining a primary union. Under such circumstances, after cleansing, it may be packed, with the precaution of provisional sutures to be tied later, should it run an aseptic course.

The various situations and the diversity in the nature of these injuries renders the discussion of their treatment necessarily a general one.

There is, of course, nothing either new or original in the treatment as set forth. It is only the practical application of well known principles to a field of minor injuries which, with proper attention, yield results pleasing alike to the attendant and to the patient who wishes to return to work in the shortest time, at as small an expense and with as little suffering as possible.

#### DISCUSSION OF DR. WILEY'S PAPER.

DR. H. G. M'NEIL:—Questioned the desirability of using a 1 to 1000 solution of bichloride in unclean wounds. Preferred a weak carbolic or formalin solution or alphozone, he having found the last named especially useful in suppurating wounds and gonorrhea.

DR. STANLEY P. BLACK:—During his internship at the Cook County Hospital, it was the bane of his existence to handle cases



of head injuries that had been tampered with by outside physicians. Christian Fenger would never see on a scalp wound. Thorough cleanliness was a matter of prime importance.

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DR. J. O. COBB:—Called attention to the necessity of exploration of punctured wounds, and cited a case of a British sailor who, three weeks prior to Dr. Cobb's seeing him, had been injured by a Jap sailor with an ordinary sewing awl. Dr. Cobb looked upon the wound as trivial, but nurse telephoned later that man was delirious. Then Dr. Cobb went in and found an egg shell fracture of skull. With proper drainage man went on to good recovery.

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DR. ADAMS:—In his ambulance service in New York city, usual method for scalp

wounds, especially among intoxicated persons, was to cleanse the scalp, shave involved area and then suture.

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DR. H. K. EMERSON:—Spoke of a patient who had a severe laceration over bridge of nose. Weak bichloride used. Very difficult to cleanse. Wound healed in two weeks, but in third week slough came to surface, showing need of care in cleansing.

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DR. F. C. E. MATTISON:—Spoke of Dr. Fenger's method of cleansing wounds with a hard brush. Would even provide drainage for clean cases.

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DR. E. H. WILEY:—In closing the discussion stated that he had seen no ill results from bichloride solution, 1 to 1000.

## AN OPERATION FOR THE PAINLESS AND BLOODLESS REMOVAL OF SUBMERGED AND ADULT TONSILS.\*

BY FRANCIS E. KELLOGG, M.D., LOS ANGELES, CAL.

The procedure which I am about to describe is in reality a modification of Pynchon's galvano-cautery dissection. In the modification, however, the role played by the cautery is less important than in the original.

*Indications:*—It is especially effective in the removal of the so-called submerged tonsil. It also has obvious advantages in the removal of adult tonsils of any class. It is in the removal of the adult tonsil that troublesome hemorrhage is most often met, and it is a matter of no small moment to be able to practically eliminate this disquieting feature.

The operation is also well adapted to the cases of submerged tonsillar stumps which are not infrequently left after tonsilotomy in children. These stumps do not usually require attention until the child has attained sufficient age to co-operate with the physician, a very essential condition precedent to the operation.

*Technique of the Operation:*—The tonsils and pillars are first brushed with a 10 per cent. solution of cocaine to secure superficial anesthesia. A few drops

of a mixture of B. Eucaïne Lactate 12 per cent. and Adrenalin 1-1000 equal parts is then drawn into a Pynchon tonsil syringe. The needle is pricked through the membrane of the anterior pillar at its middle point, and a drop of the mixture injected under the membrane.

Care must be taken not to prick through the pillar. If the membrane only is penetrated a bleb will be raised by the injection. This is repeated above and again below to cover the entire pillar. If the prick of the syringe is slightly felt at the first injection, the second and third are not felt, as a result of the first.

The anterior pillar is injected for the reason that it is liable to be touched by the cautery, and is much more sensitive than the tonsil itself.

After injecting the pillar, the needle is plunged into the stroma of the tonsil at different places, and a very little of the mixture injected at each point. Here, too, care must be taken that the point of the needle does not terminate in a crypt from which the anesthetic escapes into the throat. In the latter case

\*Read before the meeting of the Western Section of the American Laryngological, Rhinological and Otolaryngological Society held at Los Angeles, Cal., January 27th, 1906.

it can be seen running out. The tonsil after injection presents a pale, bloodless appearance. Personally, I have used a mixture of equal parts Adrenalin 1-1000 and cocaine 10 per cent., and have never gotten any constitutional symptoms except in one case, that of an anemic wash-blond, of a decidedly neurotic type. In this case the threatened syncope was averted by prompt measures. Since learning of B. Eucaïne Lactate, however, I would recommend using it in place of cocaine as the safer agent.

The tonsil is now seized with volcélum forceps at the upper third and drawn out of its recess, and at the same time pushed slightly back toward the pharynx to put the attachments to the anterior pillar on the stretch. A galvano-cautery knife at white heat is now entered at the top between the tonsil and the anterior pillar and passed downward, hugging the tonsil, and separating it well from the pillar. The tonsil is then drawn inward and forward and the process repeated on its posterior aspect. At the upper part the cautery dissection is carried deeper, as it is important to completely separate the tonsil from the supra-tonsillar fossa. In this manner the tonsil is partially enucleated by the cautery. Instead of being a sessile body it is now pedunculated, simply being attached to its bed at the base. At this point the cautery is abandoned, and the loosened tonsil drawn into the fenestrum of a Methieu's tonsillotome, and the enucleation completed.

A McKenzie tonsillotome would be equally efficacious, and a wire snare would perhaps be better than either. It would still further preclude the possibility of hemorrhage, although it would probably increase the reaction.

I have never seen any tendency to secondary hemorrhage after this operation, and believe it to be effectually prevented by the cautery, while the primary is taken care of by the adrenalin and cautery combined.

I have used this operation upon children as young as ten years of age, and had them come up smiling for the second tonsil a week after the first.

It is the proper treatment for diseased adult tonsils with a tendency to cholesteatomatous accumulations in the crypts.

#### DISCUSSION OF DR. FRANCIS B. KELLOGG'S PAPER.

DR. W. H. ROBERTS, Los Angeles:—Said he never attempted the cautery, but advocated the snare. He thought the snare safer, as the tonsillar artery might be large; used ether as an anesthetic and operated always with the patient in the sitting position.

DR. W. D. BARCOCK, Los Angeles:—Agreed in the use of the snare; thought the cautery unnecessary.

DR. E. W. FLEMING, Los Angeles:—Thought it difficult under general anesthesia to use the cautery, and that children resent an operation without anesthesia. Referring to Dr. Miller's paper, referred to tonsils as portals of tubercular and other infections, and that when diseased their removal was indicated. Many tonsils were diseased even though they did not seem to be enlarged or prominent.

DR. C. F. WELTY, San Francisco:—Referred to the rheumatic symptoms from tonsillitis, being additional indications for their removal.

DR. H. L. WAGNER, San Francisco:—Stated that he had made investigations, while in Wurzburg, of the tonsil and adenoid, both as to their structure and their absorption properties. He believed that they were foetal structures, and as such have no office to perform in after life. He had confirmed the experiments regarding the transmission of colored particles, and said the tonsil is, as it were, a lymph heart. He expected to show at the next State meeting a dog's lung, in the apex of which are colored particles that were absorbed by the tonsils and transmitted to the lung.

DR. HILL HASTINGS, Los Angeles:—Quoted a report of Dr. A. J. Lartigau from the Pathological Department of the Columbia University, who made a study of hyperplasia of the tonsillar tissue, especially in reference to the possibility of tuberculous infection. Dr. Lartigau's conclusions were, 'Primary tuberculosis of adenoids is probably more common than most previous studies show. Sixteen per cent. of our series contained tubercle bacilli, 10 per cent. with characteristic lesions of tuberculosis. The tubercle bacilli were present in small numbers. The lesions in primary tuberculosis of the adenoid are generally close

to the epithelial surface and focal in character. Occasionally they may be found in the deeper parts of the pharyngeal lymphoid tissue. It is probable from our experience that many later investigations will show primary tuberculosis in 10 per cent. or over of the clinic cases.

DR. H. A. KIEFER, Los Angeles:—Emphasized that a complete removal of the tonsil

is a difficult operation and that a rheumatic history is often found in chronic tonsillitis.

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DR. F. B. KELLOGG, Los Angeles:—Said that there are advantages of an eschar. The cautery causes a scar which most effectively destroys tonsillar tissue that might be left by a cutting or snare operation. The soreness is never more than from the use of a knife, for the cautery only separates the adhesions.

## MOUTH-BREATHING IN RELATION TO MENTAL AND MORAL HYGIENE.\*

BY ROSS ALLEN HARRIS, M.D., OF LOS ANGELES, CAL.

The philosopher-doctor who declared, "The first condition of a successful life is to be a good animal," also affirmed "A sick man is a sensual."

In spite of numerous exceptions that test the rule, we not only find but we expect to find a sane mind in a sound body, and a mind diseased in some particular, in an unhealthy body.

Of all the elements, oxygen and hydrogen in the form of air and water are absolutely essential to our existence. A man may live for a month or more without food, for three days without water, but not longer than a few minutes without air.

The all-wise Artificer has given us one mouth for the reception of food and drink, but two nostrils for the admission of air. If one nostril be stopped the other stands ready to do the work of two. If both be occluded, the mouth must needs take up a task unnatural and undesirable to itself.

The mucous membrane of the nose is eminently adapted to repel invasion by bacteria. Its cilia sweep them out as a new broom scatters dust. Its secretion will drown or collect and dessicate them. Dust and small foreign bodies are ordered back by the fine sentinel hairs. The inspired air is warmed and filtered.

A dozen micro-organisms are always normally present in the mouth. They

may be numbered by millions in filthy mouths.

The saliva—the combined secretion of the various glands opening into the buccal cavity—varies from two to three pints daily. Aside from its mechanical effect in constantly flooding the oral cavity, it possesses undoubted bactericidal properties.

Nature has thus wonderfully provided against infection. Yet given a *locus minoris resistentiae*, a solution of continuity, plus the virulent micro-organism and we have the entity called disease.

The mouth-breather inspires dust and microbe-laden air, and dries too rapidly the moisture of the mouth. The immediate result is a turgescence and hypertrophy of the mucous membrane, followed eventually by atrophy. Dr. Henry Green speaks of a man who contracted conjunctivitis from the action of a draft through a keyhole upon his eye. The mouth-breather has a constant draft playing upon his pharynx, drying and chilling it. In this way contagious disease of every sort may be contracted, not only the catarrhal but the exanthematous.

Campbell reports three cases of iritis in which there was an absolutely negative history of either syphilis or rheumatism, but in all three there was marked evidence of oral sepsis.

\*Read before the meeting of the Western Section of the American Laryngological, Rhinological and Otolological Society, held at Los Angeles, Cal., January 22d, 1906.



If pneumococci or tubercle bacilli be absorbed through pathological openings in the mucous membrane of the mouth, or swallowed in a bolus of mucus, they are carried to the lymph-nodes of the neck or lungs. The inflammatory reaction of pneumonia or tuberculosis results.

At Portland the declaration was made that not a few of the affections of the heart valves ordinarily attributed to rheumatism resemble those produced by septic conditions much more closely than had been imagined. Marshall says that 90 per cent. of all compound fractures of the jaw suppurate.

It is in the throat that we find local manifestations of many constitutional diseases, as influenza, diphtheria, varicella, measles, scarlet-fever, smallpox, and here it is that actinomycosis has its native dwelling place.

The causes of mouth-breathing are manifold; adenoid growths in the nasopharynx being the commonest; deflections of the nasal septum; hypertrophy of the turbinate bodies; acute or chronic catarrh; nasal polypi and neoplasms.

The diagnosis of mouth-breathing is not always easy. Of course the facies of the common victim of adenoids and hypertrophied tonsils is ever characteristic. The drooping jaw, narrow and inactive nostrils, lustreless eyes, the partial ptosis, the crowded teeth—are so diagnostic as to scarcely require mention.

But careful scrutiny will discover that many an active, bright-eyed boy or girl breathes habitually with parted lips. These intelligent youths may progress just so far in school, but will then seem to be unable to make further advancement.

The fault is laid to nervousness, to defective eyes or to innate depravity. The nervousness is attended to by drugs containing more or less alcohol; the depravity by nagging or stupid punishments; the eyes maybe are fitted with quarter-diopter spherical lenses. All

myopia and all astigmatism should be most accurately and constantly corrected, but the average healthy American child should be able to easily overcome one-half a diopter of hyperopia, and this action of a normal accommodation will be all the more wholesome for his future vision.

Should the drugs, the scoldings and the optician have failed to improve our patient, let us examine him as to catching cold easily, snoring, night-restlessness, a dry throat on waking, and finally with the nasal speculum, the laryngoscope or the visual organ in the tip of the index finger.

Is the mouth-breather doomed to a life-long continuance of his habit? Not if the cause be adenoids or hypertrophied tonsils. As the years pass, usually at puberty, these morbid growths will atrophy and practically disappear. Would that the harvest of their sowing might go with them. But the horrid crop remains.

The chronic nasal catarrh, the atrophic rhinitis, the mephitic ozena, the dread suppurative otitis media, or the great white plague have begun or done their fearful work.

As sequelae to these direct physical effects, and following their debility and exhaustion, are exhibited anemia, indigestion, insomnia, constipation, and rheumatism—that happy term covering a mountain range of our ignorances. And these diseases are the prophetic forerunners of neurasthenia, the neuroses and the psychoses. The mouth-breather being out of harmony with his environment, his moral nature is bound to become perverted.

As one in every ten among the school-children of our large cities will be found to be a mouth-breather, and one in five will be found to have enlarged cervical glands, we would urge the following remedies:

1. Monthly inspection of all public schools and juvenile institutions by competent physicians.

2. School instruction regarding the causes and results of mouth-breathing, with lessons in the hygiene of the month and nose.

3. The urging by physicians of speedy operation whenever this condition is encountered.

The mental and moral effects of the removal of the commonest cause of mouth-breathing was first commented on—not by a member of the medical profession, but by a layman, Mr. Edward A. Huntington, principal of a special school in Germantown, Pa.

To his instructive list of reported cases I would add these few, to call attention again to the baneful influence of this unfortunate habit upon dispositions and character.

*Case I.*—Charles W. Age 8. Always a mouth-breather. Catches cold easily. Chronic suppurative otitis media for six years in left ear. Enormous faucial tonsils, almost meeting together in the throat. Large adenoid mass in post-nasal space. Mother says the boy is very nervous and irritable. Cannot keep still in school. Is often kept after school for punishment. The teacher sent home a note saying the boy was always fighting.

The boy is a center of mischievous activity and cannot keep his friends long. Cries and laughs very easily. Is constantly moving hands, feet or tongue.

Operation, double tonsillotomy and adenectomy. Operation for otitis media refused. Patient's improvement in general health and in school was very encouraging for one year, though he suffered much from recurrent sore throat, and breathed most of the time with open mouth. This was supposed to be a continuance of the life-long habit, but examination showed both tonsils again enlarged, the left one especially so. This one being removed while acutely inflamed the entire throat became better, though the mouth-breathing continued. The pus from the sup-

purating ear was examined at this time. It showed only "dead" cells and *staphylococcus aureus*, no streptococci being present.

The mother tried to bring about a good habit of mouth breathing by a sort of cloth bridle which bound up the chin with buckle and strap. The device never proving very satisfactory a strip of court plaster was pasted across the boy's lips on retiring. This effected the purpose indeed, "not wisely, but too well." Hearing strange sounds one night she entered the room where the boy was sleeping and found him writhing in a convulsion, with vomitus pouring from his nostrils. She tore off the plaster as quickly as she could (it isn't easy to remove court-plaster, either,) and the pillow was deluged with the remains of a hungry boy's supper, together with a quantity of popcorn he had eaten in the evening. The boy might have been drowned in his own stomach but for this timely intervention.

The attempt at mechanical closure of the lips was abandoned, and moral suasion tried while the boy was awake, with a low pillow while sleeping.

Today the boy is a healthy-looking lad who breathes through his nose most of the time. His last deportment card in school was marked "Excellent," and almost every study showed "Good" or "Excellent." He is a manly boy, with ideals high enough to make him a favorite with teachers and playmates. He bids fair to become a useful and healthy American citizen.

*Case II.*—Helen G. Age 4. For two years it has been my privilege to observe this child, who, but for her affliction, might well be termed a degenerate. Is not degeneracy the result of faulty habit and environment, as well as of heredity?

She is a fair-skinned, tow-haired, well-developed daughter of refined and wealthy parents. General health excellent, but always breathes with open

mouth. Is sick in bed with a cold or tonsillitis every month or two. Is highly imaginative, and untruthful in so much that her mother cannot permit her to attend Sunday school, for on her return she will invent the most impossible fictions that a morbid mind could conceive.

Her play with other children invariably ends in woe to her playmates. She is cruel. She says "I like to slap your little girl because I like to hear her cry." She is undutiful. When her mother calls her she refused to answer, remarking, "She doesn't really want me, she is just calling because she doesn't know what else to do." And, "I like to make Mary do things you don't want her to do, so she won't mind you." She is vindictive. When reproved by a neighbor she threw stones at the baby saying she hoped one of them would kill it. Insolent to passers-by, strangers wonder at her insulting remarks or gestures. Obscene to a degree, she is the horror of every parent in the neighborhood. When she entered school last September the teacher, glad of any excuse to oust her, declared that as she could not write she must be put in the kindergarten. She is as unwelcome there; and altogether the case is a pitiful one. Her father will not entertain the idea of an operation on a child so young for a habit which she will certainly outgrow!

*Case III.*—Hazel P. Age 11. This very elegant young lady appeared with her mother at the Eye Clinic of the Medical College, U. S. C., for refraction. Her attire was so startling in a free dispensary that its description may be pardoned. The latest coat, a large Gainsborough hat, white kid gloves, patent-leather shoes, and well-powdered face completed an extraordinary and unattractive picture. The mother said her daughter had always been nervous, had headaches "across her nose," caught cold easily, was irritable and could not study. The family physician thought

she would be benefited by wearing glasses.

Nervous she certainly was. All children are naturally far-sighted, but the most painstaking examination of these eyes showed only a trace of hyperopic astigmatism for which she would accept no correction.

But the crowded and prominent front teeth, the parted lips, the constant sniffing, the high-arched plate, and finally the large adenoid vegetation discovered in the roof of the pharynx, showed the true cause of her nervousness. Transillumination showed both frontal sinuses dull, and this child was only eleven!

I said, "Madam, your child does not need glasses, but she does need an operation," the nature of which was explained to her. "Oh," she replied, "that mouth-breathing is only a habit. She will outgrow that. I have talked to her a great deal about it, and told her how it looked, and she isn't nearly as bad as she was."

Arguments and prophecy were alike unavailing, and the pair departed firmly antagonistic to doctors who always wanted to "operate."

How about the future weal of this child?

*Case IV.*—Loren S. Age 12. Has always been a mouth-breather. As soon as he recovers from one cold, he catches another. Snores a great deal. Will not keep covers on the bed at night. Irritable. In school his progress was never satisfactory. Loved to tease younger children, especially his brothers and sisters.

Nose was unusually small and ill-developed even for a mouth-breather. Alae short and flat. Roof of mouth not especially high. Large faucial tonsils and adenoids. Uvula elongated. Operation on these abnormalities was followed by great improvement in demeanor and in school reports. But the mouth-breathing persisted. The court-plaster method of cure was in vogue at



the time (it was before the disastrous experience of Case No. I). The mother tried it faithfully. She said she was alarmed one night by the wierd, unnatural sounds coming from the boy. She found him tossing, moaning, and somewhat cyanotic but still asleep. She took off the plaster and the boy became quieter. It would seem as if Nature cries out for just so much oxygen and will have it whether by nose or mouth.

Loren has practised nose-breathing by running a block with closed mouth. Gradually increasing the distance he has not only overcome his bad habit but has developed sturdy legs and lungs.

At this writing, two years after operation, this boy, now 14, has just bloomed into a virile manhood. He is first assistant to a busy mechanical engineer, who tells me he is the best man in his employ and will make a successful engineer.

*Case V.*—Mrs. G. H. D. Age 72. Earache for several nights. Tinnitus aurii, constant. Catches cold very easily. Frontal and temporal headaches. Tonsils were removed 62 years ago. Catarrh for many years. Used to cry with earache when a child. Has been treated in every large city from Washington to San Francisco. Great, green, decomposing and foul-smelling crusts partly occlude both nares. Frontal and maxillary sinuses dark on transillumination. The sense of smell has been entirely lost for years. Breath fetid. Watch heard in right ear at eight inches. In left ear at eighteen inches. Both tympanic membranes retracted.

The earache soon subsided under hot irrigation, but no amount of cleansing and stimulating treatment served to do more than alleviate temporarily the nasal symptoms.

This venerable and venerated lady is convinced that she was a mouth-breather during the years of her childhood, and to this she attributes her present condition. Her ozena annoys

her no more than it does other people. "Isn't it strange," she said to a friend, "that with all my catarrh there isn't any odor?" With averted head her friend answered that it was. Possessed of ample means, she could choose any hotel in the city for an abiding place, or would be welcome at her only son's palatial home in a distant town. But, self-exiled, she lives alone in a single room, doing light house-keeping over a kerosene lamp-stove.

"It's a very poor arrangement, this dying," she avers. Afraid to die, without comfort or hope, she flits about from house to house, never keeping the same address long, but always attended, wherever she moves, by this fearful "old man of the sea."

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#### DISCUSSION OF DR. HARRIS' PAPER.

DR. E. F. CHURCH, Los Angeles:—Congratulated the essayist on the able manner in which he had covered the subject. Was especially interested in the case histories.

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DR. H. L. WAGNER, San Francisco:—Mouth breathing was interesting from anatomic, physiologic and psychologic grounds. Spoke of ethmoidal sinus, the lymphatic vessels and the efferent nerves and the manner in which they made their way through the cranial bones. Referred to the work of Renzlers of Danzig. The laity will more willingly consent to operations, once they are educated to their value in these conditions. Cited cases in the literature, all men and all drunkards, who after adenoid operations, became raving maniacs, showing close connection between nose, throat and brain.

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DR. A. L. KELSEY, Los Angeles:—Felt that Dr. Harris' paper should have been presented before general practitioners, since it is the general practitioners who see these cases first, and as the general practitioners are only too apt to hold to the belief that the adenoids nearly always atrophy as the child grows older, such a paper as Dr. Harris' would have rendered valuable aid in disillusioning their minds of such a fallacy. Spoke of three post-adolescent patients all well on in the prime of life, on whom he had operated for adenoids.

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DR. C. E. WELTY, San Francisco:—Spoke of the tonsillar and pharyngeal tissue as the entrance way of infections such as tuberculosis. Cited case of a recent patient, a boy of 14, in whom tonsils had been removed by another practitioner; the operation, however, being followed by suppurative processes. An

acute nephritis accompanied the local disturbance, but disappeared as the suppuration ceased.

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DR. E. W. FLEMING, Los Angeles:—Stated that there were patients with adenoids in whom general condition was good, but who were troubled greatly by the mouth breathing, and with whom it was very hard to get a good response from treatment. These patients are usually children, ages 4 to 10, who possess a decidedly V-shaped and narrow, hard palate. In such patients, even after the removal of post-nasal obstructions, mouth breathing may continue. The difficulty in dealing with the hard palate makes brilliant operative results in these cases impossible.

DR. H. BERT ELLIS, Los Angeles:—Referring to the class of patients mentioned by Dr. Fleming, stated that it was his custom to refer all such to a dentist after his own work had been completed.

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DR. ROSS HARRIS, Los Angeles:—Referred to the saying of Dench, he thought it was, who made the statement, "Every cold in a child is due to an adenoid." No child was too young to be operated upon. His paper had not been intended to be technical, but was intended rather to show the disastrous effects of non-interference at the proper time. The importance of early operation in this class of patients cannot be exaggerated.

## SAN DIEGO AS A HEALTH RESORT.

BY THOMAS MAGEE, M.D., HEALTH OFFICER OF THE CITY OF SAN DIEGO, CAL.

Two features enter into the well being and preservation of health of every individual. The first is personal conduct, over which there is self-control and individual responsibility. The second is environment, the most important of which may be stated to be climatic condition of residence.

Under the former may be classified the methods of home life, such as regularity in eating, rest, moderation in exercise or labor and a judicious and careful selection of wholesome food. Pure air, pure water and wholesome food, aside from personal conduct, are the elements necessary for health and longevity.

The purity of the atmosphere at San Diego, its freedom from miasmatic emanations, its admitted impregnation with ozone as it sweeps in from the westward over the broad Pacific, are such well established facts that they need only mentioning to commend their truthfulness to the reader.

### CONTINUOUS ATMOSPHERIC MOVEMENT.

A factor which enters largely into the sanitary conditions of San Diego is the prevailing winds. Observation has established the fact that the highest state of healthfulness exists when there is a continuous atmospheric movement.

When this movement falls under 100 miles in the 24 hours, there is at once a decided impression on the public health for evil, a marked increase in sickness and a rise in the per cent of mortality. In San Diego we have not only an atmosphere free from disease germs, but an average daily velocity of 140 miles in 24 hours, which continues from day to day with but little fluctuation during the entire year, thus demonstrating the impossibility of atmospheric contamination from any local source if any such source existed.

### PLENTY OF SUNSHINE.

Again, the most thorough renovator of the atmosphere is sunshine. It is a well established scientific proposition that the most virulent disease-producing germs become innocuous when subjected for any length of time to the direct rays of the sun. Southern California in general and San Diego city and county in particular is the land of perpetual sunshine. Here the days that are devoid of sunshine during an entire year may be counted on the fingers. Even during the rainy season the larger part of the rainfall occurs during the night. A common occurrence is after a heavy downpour through the night, sunrise is ushered in with a clear sky and cheerful sunlight, lasting during the day.

In most regions the clear, pleasant days are so rare that when they do brighten the life they are the subject of universal remark. Here in San Diego it is only the occasional beclouded day that forms the subject of comment.

#### PURE WATER SUPPLY.

Recently the city authorities have entered into a contract with the Southern California Mountain Water Company to furnish the city with an abundant supply of pure water from the mountain regions in the interior of the county. The watershed from which this supply is impounded being from a region practically uninhabited, will be free from those pollutions which render it unwholesome, so that water-borne diseases which prevail so largely in most cities, will be in the future, as in the past, practically unknown in the city of San Diego. Aside from the water supply of the city, there are numerous mineral springs scattered throughout the mountainous regions of the county, easy of access and possessing health-restoring qualities equal to those in any part of the world.

#### GOOD FOR THROAT AND LUNGS.

These health-restoring fountains are found along the foothills and in the mountains where the atmosphere is of the most balmy character and where outdoor life rises to the highest state of perfection. Along these foothills where fogs are unknown and perpetual sunshine brightens the day and clear, starry skies the night, the valitudinarian with throat and pulmonary affections will find the ideal conditions on which the modern methods of successful treatment are based. The victim of the white plague, availing himself of these conditions in the early stages of the disease, will find his cough steadily improving, his expectation ceasing, his night sweats drying, his appetite returning and his strength steadily gaining. The valitudinarian with a death-like struggle for

breath, which renders life a burden, will find the air passages free, so that he can stand erect and breathe with an ease and independence that gladdens his heart and brings an unknown joy into his life.

#### EQUABLE CLIMATE.

The climate in this region is conceded to be one of the most equable known to man, the mean being 61.3 covering a period 66 years, and this is from a range rarely rising above 80 degrees, or falling below 44 degrees, and falls precisely in the register of what physiologists consider the most desirable temperature for the comfort and well-being of man, viz., from 60 degrees to 65 degrees F. Yet it is necessary for the inexperienced to have a few facts concerning its peculiarities well impressed on his mind and govern himself accordingly.

#### HEAT TEMPERED BY COOL BREEZES.

While the direct rays of the sun come down with as much power here as elsewhere in the same latitude, the modification of this heat is the result of the cool breeze from the Pacific ocean, which is ever present.

This cool atmosphere from the ocean rapidly abstracts the heat from the body so that one needs to be as warmly clad to maintain the body temperature here as in regions where the thermometer marks a much lower temperature, consequently tourists coming here to San Diego or other parts of Southern California, to escape the rigors of an eastern winter and provided with a wardrobe suited only to eastern midsummer, find they have made a great mistake.

#### NO PREVAILING DISEASE.

The health office is constantly in receipt of inquiries from physicians in the East as to the prevailing diseases in this city and vicinity. Now, there are no prevailing diseases epidemic to this locality, for the reason that there



are no local conditions natural to the county to generate disease.

The oppressive heat of summer which develops the destructive diseases of infancy, and the autumnal fevers, attended with such high mortality in the East, is unknown here. During the year ending December 1st, 1905, the record shows but four deaths from cholera infantum, and but three from infantile convulsions. Whooping cough, which has prevailed throughout the city for the past year and which has a record of being one of the most fatal of the infectious diseases of childhood, is accredited with but one death during the year. In a record of 150 consecutive cases of scarlet fever to date there is but one death accredited to that disease. Typhoid fever during the year has only four victims to answer for.

Owing to the dryness of the soil, the continual sunshine and constant change in the atmosphere from the ocean, unimpregnated with any disease-producing germs, all infectious diseases are extremely mild in their course. Wounds and injuries heal kindly and surgical operations have a very low mortality.

Diseases peculiar to the winter months in the East and due largely to the severe cold and frequent and extreme atmospheric changes are among the rare affections in San Diego. Pneumonia, croup, severe bronchial and rheumatic diseases are of rare occurrence here, except as the legitimate relic of physical infirmities contracted in other less salubrious regions and brought here by health-seekers.

#### NO MALARIA OR YELLOW FEVER.

The two maladies, which of all others are most dreaded in tropical and semi-tropical regions, malarial and yellow fevers, are scourges which need never be apprehended or feared in San Diego, as there are no conditions existing necessary for the development and propagation of the species of mosquitos which transmit these much-dreaded disorders to the human species. It is a well recognized fact that until quite recently the great majority of the residents here in San Diego and vicinity have sought the comforts of this region, either for individual health or the health of some member of the family.

## DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M.D., EDITOR.

### EDITORIAL COMMENT.

**INTESTINAL NEUROSES IN WOMEN.**—The anatomical structure of the intestines renders them favorable sites for neuroses. Increased irritability of the nerves which are in direct or very intimate connection with the spinal or cerebral systems and also with the nerve supply of contiguous organs is the essential underlying factor. The study of these diseases is rendered doubly hard because our knowledge of the anatomy and physiology of the intestinal tract is not as full as we would wish it.

In order to classify the diseases as intestinal neuroses we must, of course, exclude all demonstrable pathologic or anatomic alterations, a matter sometimes very difficult of accomplishment. The text-books and the journal literature are peculiarly destitute in the consideration of intestinal neuroses and only within a few years have the investigations and writings of Mall, Hemmeter, Nothnagle, Houkgeest, Einhorn, Boas, Leube and others placed the diseases on a firm scientific basis.

The Germans have been most active and most of the literature is found in

German periodicals. These writings seem to show conclusively that the intestines have both sensory and secretory nerves and that they are probably reflexly excited by the gastric nerves, indeed the relation between the neurones of the stomach and those of the intestines are most intimate, in many instances they are combined.

Peristaltic unrest is usually seen in nervous, hysterical women or those who are hypochondriacal. It is a marked increase in the normal intestinal movements due either to increased excitability of the motor or sensory nerves of the intestines or to systemic toxic irritants from the blood stream, or again to local irritants acting directly on the intestinal mucosa. We must not confound peristaltic unrest with the increased peristalsis that is seen in intestinal occlusion, chronic stenosis, catarrhs and diarrhoeas; in these conditions when, in addition to the anatomical alterations there is decomposition and fermentation of food, the peristaltic action may be very excessive.

It is increased peristalsis without any objective anatomical changes that is called peristaltic unrest.

This will be accompanied by subjective sensations, contraction and uneasiness of the intestines, cramp-like pains, sometimes borborygmus, rumblings, gurglings and swashing. These latter may be loud enough to annoy the patient and be heard by others close by.

If the motor nerves alone are involved all the concomitant complaints are less marked. In these patients the intestinal noises and the retained stools are about their only complaint, they are sometimes kept from sleep by the extreme activity of the peristalsis, the noises and gurglings. The stomach may take a part in the tumult.

It must not be forgotten that peristaltic unrest may occur in persons who are apparently perfectly healthy and in

those who give no evidence at all of the neurasthenic state. In these people it quite often arises at pregnancy or menstruation or after the ingestion of highly seasoned or indigestible food; mental excitement and tight lacing have been added as causative factors.

In a large portion of these cases the symptoms will arise without any known cause. Curiously enough the increased peristaltic action does not produce a frequent thin watery stool but rather a condition of retained stools. This is due to the sluggish action of the large intestine in comparison with the great activity of the smaller gut. The German writers rather think that this form of constipation or stool retention is due to anti-peristaltic movement in the large intestine; where the two movements conflict fecal accumulation occurs.

In an interesting contribution in the *Arch. f. Verdaunks-Krank.* Bd. viii, Hefte I, T2, Hemmeter in studying intestinal anti-peristalsis seems to have demonstrated a movement of small particles, in man, from the rectum to the stomach. The movement occurs along the walls and while the upward movement is active, there is also a central downward movement of the fecal masses. The anti-peristalsis, however, cannot move ingesta in large masses. The strong visible anti-peristaltic movements of Nothnagle occur only under abnormal conditions.

Koplan in the *Gaz. Hebdomadaire de Med. et de Chir.* 1901, No. 70, has described a condition which he calls nervous pseudotympany or accordion abdomen. Here there is either a general distention of the abdomen, or a partial distention limited to one or more regions, which collapses under narcosis, without the escape of gas, either through the mouth or anus. It reappears as the narcosis passes off. It may appear very rapidly and disappear just as rapidly. The patients are usually hysterics and of

eighteen cases, sixteen were women. The distention may be so pronounced as to produce asphyxia. Anatomical alterations are not demonstrable.

The most exaggerated form of peristaltic unrest is that in which the waves take opposite directions, that is one wave upward toward the stomach and the other downward toward the rectum, and results in stercoraceous vomiting.

The general diagnosis of peristaltic unrest can usually be made with a fair amount of accuracy. The other nervous symptoms which are present, aid very much in determining the existence of a neurosis. The case which has an anatomical basis, can easily be excluded from those which are purely neurotic. The prognosis is never grave and it is apt to be quite favorable except in those cases in which there are demonstrable changes in the nerves, particularly the splanchnics.

## REVIEW OF THE LITERATURE.

### THE OPERATIVE TREATMENT OF INTRA-CRANIAL HEMORRHAGES OF THE NEW-BORN—

We propose this month to anticipate a topic which in the future will possibly bulk largely in relation to the prevention of a condition that hitherto has been in no wise amenable to treatment. We refer to certain varieties of Little's disease, or spastic diplegia.

An important cause of this affection is meningeal hemorrhage occurring at, or soon after birth. The pathogeny of this hemorrhage is by no means fully understood as yet, though distinct advances in our knowledge have been made of late in this country, especially by Howell Evans. It seems certain that the accident may take place in cases giving no history of unusually dystocic labors, or of difficulty in the induction of natural respiration in the infant. It is none the less certain that once the accident has taken place the only chance of preventing either death or

permanent after-effects lies in early diagnosis and immediate treatment of the hemorrhage on established surgical principles. Up to the present it is surprising how rarely this obvious procedure has been resorted to.

Harvey Cushing (*Amer. Journ. Med. Sci.*, October, 1904.) has recently reported four cases of intra-cranial hemorrhage in the new-born in which he has resorted to operation for the cure of the condition, two of these being successful.

The first successful case was that of a child eight days old with unilateral hemorrhage, and the second was that of a child of nine days with bilateral hemorrhage.

When operating, Cushing turns down one or both parietal bones, opens the dura mater, removes the blood and blood-clot, and irrigates the surface of the brain with warm salt-water.

He recommends operation as soon as the diagnosis can be made, and when operating to avoid exposure and loss of blood.

In Cushing's opinion the diagnosis of the condition is not difficult. He relies upon the following points: (1) Asphyxia at the labor; (2) a tense and probably non-pulsatile fontanelle; (3) the onset of convulsions a few days after birth; (4) undue reflex excitability; (5) ocular palsies and unequal pupils.

When these signs are equivocal or absent, he maintains that the diagnosis can be settled by lumbar puncture, which, as in the adult, always reveals blood-containing fluid in cases of meningeal hemorrhage.

Cushing further regards intra-cranial hemorrhage as due to strain on the cortical veins from over-riding of the parietal bones during the birth.

But there is another explanation. Howell Evans (reports of the Society for the Study of Disease in Children, vol. iv, pp. 100-106; *British Journal of*



(*Children's Diseases*) in a communication to the Society for the Study of Disease in Children, in January, 1904, pointed out that these hemorrhages are due to rupture of the blood-vessels passing through the parietal bones from the scalp to the interior of the skull, via the sagittal fontanelle, the intraparietal suture, or the parietal foramina, as the case may be, laceration being due to the over-riding during labor of those portions of the parietal bones in relation to these structures. He also affirmed that the condition is more liable to be found in connection with that parietal bone which lies outermost.

Rupture of these vessels produces either a cephalhæmatoma externa or interna, or intra-cranial hemorrhage, or a combination of these conditions. Hemorrhage, according to Evans, takes place during the reactionary period after birth; subsequent to birth alteration in the blood-pressure comes on gradually, and about the third day the tension is markedly increased, and it is at this period that cephalhæmatomata are most prominent. Infantile blood is very deficient in clotting power, as Scherenzies was the first to show, and with the rise of blood-pressure a weak clot is apt to be displaced.

Cushing has proved that cases of intra-cranial hemorrhage are amenable to surgical treatment, but the signs on which he relies for its early diagnosis are open to the criticism that they are often not present.

Asphyxia at the birth is frequently absent; in many cases of spastic paralysis, which were presumably caused by neonatal hemorrhage, labor has been natural. If the hemorrhage is very extensive, or if it be at the base, the infant usually dies at once. Should it survive the accident it is dull or stuporose, with slow, irregular respirations and a slow, feeble pulse.

Convulsions are common four or five days after birth, with cortical hemor-

rhages, but they are less frequently met with in extravasation of blood at the base, and they may not be present in any case. The majority of the fatal cases die within this period. Associated with convulsions may be opisthotonos and rigidity of the limbs, or muscular relaxation may be a feature, or there may be automatic movements. There is usually no obvious paralysis at first, perhaps not for some months.

But localized cortical hemorrhage may cause corresponding paralysis—*e.g.* facial paralysis, hemiplegia, monoplegia, and diplegia. The mildest cases usually do not give rise to symptoms; on the other hand, a large hemorrhage is often immediately fatal, though extensive cortical hemorrhage may not kill the infant. Oscillation of the eyeballs and contraction of the pupils rather than dilatation are sometimes present, but they cannot be considered important signs. Bulging of the fontanelle only occurs with a large hemorrhage.

Given, then, that the condition be recognized, Cushing has demonstrated that there is considerable hope that such cases in the future will be amenable to surgical relief, a marked advance on the present treatment of this hitherto hopeless condition.

One note of caution comes from Danielewsky. This worker, whose experiments have been confirmed by Jean Demoor, asserts that the trephining alone of young animals, apart even from opening of the meninges, leads to epilepsy in later life, notably at puberty. The factors concerned in this process and the exact conditions under which it arises are well worthy of further study. It is clear, however, that such remote possibilities, which have not been shown to be operative in the human, should in no way deter a surgeon from the application of his recognized principles in the treatment of such a grave condition as meningeal hemorrhage—*Brit. Journ. Chil. Dis., Dec., 1905.*

### THE COMMUNICABILITY OF CEREBROSPINAL MENINGITIS.—

E. M. Buckingham in a short communication shows not how the disease is spread but how little danger there is of communicating the disease from patients to nurses or to other patients in the same ward. At the Children's Hospital, in Boston, cases of epidemic cerebrospinal meningitis are not isolated, but are treated in the medical wards along with other cases. Aside from the usual cleanliness and good nursing no precautions are taken with these patients. During eight years up to 1904, there were 110 cases of epidemic cerebrospinal meningitis admitted to the wards. Of these, 16 cases were in the wards at one time. Notwithstanding the mingling of these patients with others in the medical wards, not a single case of epidemic cerebrospinal meningitis originated in the hospital, among either patients or attendants of whatever grade. Buckingham concludes that living in the same room and breathing the same air with patients ill with this disease is not of itself dangerous, and that some other mode of transmission must be sought.—*Boston Medical and Surgical Journal*, April 20, 1905, p. 461.

### BOOK REVIEWS.

THE PHYSICAL EXAMINATION OF INFANTS AND YOUNG CHILDREN. By Theron Wendell Kilmer, M.D., Adjunct Attending Pediatricist to the Sydenham Hospital; Instructor in Pediatrics in the New York Polyclinic Medical School and Hospital, New York; Attending Physician to the Summer Home of St. Giles, Garden City New York. Illustrated with 59 Half-tone Engravings. 12mo., 86 pages. Bound in Extra Cloth. Price, 75 cents, net. F. A. Davis Company, Publishers, 1914-16 Cherry street, Philadelphia, Pa.

While we cannot agree with the author's statement that the physical examination of infants and young children is a subject in which nearly all of the text-books on Pediatrics are deficient, we still feel, however, that we are indebted to him for a very valuable contribution

to the subject. We unqualifiedly agree with him that the training of most physicians has been along the lines of the physical examination of the adult and that it is in the knowledge of the physical examination of children that the average practitioner is deficient. We must not, however, forget and unlearn all the things we ever knew about adults when we come to the examination of children; they are not an entirely different proposition as the author states, but rather a modification of the same proposition.

Like the author, it has also been our privilege to watch hundreds of students examine infants and children, and such teaching has led Kilmer to write the little volume under review.

No attempt has been made to outline physical diagnosis nor pathological conditions; the sole aim is to instruct the student and physician how to examine a baby.

The book is illustrated with fifty-nine half-tone engravings; they are all good, relevant and appropriate, and show no padding. In fact, a careful reading of this little book leaves one with a feeling of satisfaction in that the work has been well done and that the book is a safe one to recommend to students. Many, in fact most practitioners, would do well to have this book in their library.

W. A. E.

\* \* \*

CLEFT PALATE AND HARE LIP. BY W. Arbuthnot Lane, M.S., F.R.C.S., Surgeon to Guy's Hospital, and Senior Surgeon to the Hospital for Sick Children, Great Ormond street, London. The Medical Publishing Company, Limited, 1905. Price 5 shillings.

It is probable that congenital hare lip and cleft plate has occurred from the time of the first appearance of man on earth, but only scanty references to this deformity are found until nearly modern times. While we have discarded "Maternal impressions" as causative agents in the production of these deformities,

we have no very satisfactory reasons to offer in their stead.

Undoubtedly surgeons saw this deformity from very early times, but not until the seventeenth century was any attempt made to correct the conditions and then only the cleft in the lip was closed.

Since then, of course, we have advanced very far in these cheiloplastic operations and are all now agreed as to the main principles governing the operations for hare lip and practically all agree that postponement of the operation beyond the second year of life is unadvisable.

The unanimity, however, does not exist in regard to congenital cleft of the palate. It took a long time for surgeons to be daring enough to close more than clefts of the velum palati, and in which the separation of the two halves was but slight.

Closure of clefts of the hard palate was not attempted for many years after staphylorrhaphy had become a frequent operation. The credit of this advance belongs to an American physician, Warren of Boston, who in 1843 raised the muco periosteum from the palate bones on each side and brought these together in the middle lines. Thomas Smith of England in 1869 showed that the risk of asphyxia from hemorrhage had been much exaggerated if good care was taken and that it was justifiable to administer anaesthetics for the operation. Smith's cleverly contrived gag so fixed the jaws and tongue that the willing and intelligent assistance of the patient was not required. This of course advanced the operation very much and the tendency to the earlier performance of staphylorrhaphy and uranoplasty became evident.

The best age at which to do this operation has received much discussion. Mr. Lane, the author of the book under review is the chief advocate of the very

early performance of these two operations. His arguments in favor of an early operation are these: The abnormality is an arrest in development, the sooner the parts are placed in their normal positions the more likely is development to proceed along normal lines.

If the palate is reconstructed before any attempts at speaking are made it is highly probable that the voice will not be "nasal."

The surgeons who are opposed to early operation argue that the risk of sepsis at a very early age is greater; the tissues are more likely to slough and are more lacerable than later; older children are more easily kept quiet after the operation and that the voice differs but little from the normal if the cleft is closed before the fourth or fifth year. Time will show which view is the correct one; perhaps we will settle down to a mid-period between the early period of six months as advocated by Lane and four or five years as advised by other surgeons. When we consider that the sooner the cleft is closed the more readily will development approach the normal, the argument for early operation becomes very strong. The modern methods in surgery do much to counteract the dangers of sepsis, sloughing and shock to even very young babies. The one great factor in our mind is the individual skill of the surgeon; under ideal conditions the early operation is in our opinion that which should be advised and we fully agree with the author in his advocacy of the six months period.

The book is a joy to read on account of its type, which, as the *British Medical Journal* says, is a "sight for sore eyes," so large and light is it. The illustrations are beautiful and appropriate.

W. A. E.



## DEPARTMENTAL

## DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTENGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

**THE EVILS OF ADVISING POVERTY-STRICKEN CONSUMPTIVES TO CHANGE CLIMATES.**—One of the crimes of the medical profession against the poor consumptive has been that of advising him to leave home and friends to seek health in some far-off clime, when he had no means of support when the new climate had been reached.

Those of us who practice in health resorts understand this in a manner that those who give such thoughtless advice cannot appreciate.

Hundreds of poor patients come to California every year, who would have much better chances of cure if they remained at home. They often arrive here without means sufficient to support them even a month. They expect to fall into a job at once, forgetting that there are hundreds of others who have come with the same expectations. They drift into cheap lodging houses, and poor restaurants and thus they lose any benefit that they might have gained had they been able to live right.

Another shame is, that many of these patients are so far advanced that they could not hope to be cured by climate, even if they could live under the most favorable circumstances.

It has been so thoroughly demonstrated that tuberculosis can be cured in climates which are not especially favorable, that the question of a cure in this disease is a relative matter. The matter might be summed up as follows: That climate is best for the treatment of a given case of tuberculosis where he can live under the most favorable circumstances and have the purest air,

the best food and the most intelligent guidance. This means that the poor fellow who finds it necessary to spend all his money for railroad fare would have far better opportunities of getting well if he were to remain at home, even in crowded cities, and spend his money for a good sunny, well ventilated room, and good food.

With the many tuberculosis dispensaries which are now being operated in the eastern cities, there are opportunities where the worthy poor can have intelligent medical care. In this way, they can make good use of a bad climate, while if they change, they will be forced to make bad use of a good one. There is no question but that the former plan offers the greater hope of recovery.

I do not wish to under-rate the value of climate. There can be no doubt of the influence of favorable climates upon the arrestment and healing of tuberculosis; but, if an individual is to derive benefit from a change, he must have sufficient means to support himself when he reaches the favorable place.

Eastern physicians are beginning to realize the great mistake which they have made and are still making, in advising poverty-stricken patients, suffering from tuberculosis, to leave home, and seek health in some distant country. They are beginning to realize how unfair it is to send these unfortunates away from home to become objects of charity upon a community in which they have perhaps lived only a few weeks or months.

That the medical profession is awakening to the evil of this practice is evidenced by the following letter, a

copy of which was mailed to 8000 physicians in New York City by the Committee on Prevention of Tuberculosis of the Charity Organization Society during the recent tuberculosis exhibit:

NOVEMBER 27, 1905.

*Dear Doctor:*

The Committee on the Prevention of Tuberculosis of the Charity Organization Society takes this opportunity, while the American Tuberculosis Exhibition is being held at the Natural History Museum, and while the subject of tuberculosis is prominently before the community, to call to the attention of the medical profession of the City of New York the consequences arising from the practice of sending poor consumptives to such states as Arizona, Colorado and California. Extensive experience has taught us that, difficult as it may be for a poor man to recover from tuberculosis in this city, he is better off here among his friends and relatives, where there are more adequate hospital and dispensary facilities, than he is far from home, where he is thrown entirely upon his own resources and where the great number of consumptives willing to work at the lowest wages make the finding of

employment, especially of suitable employment, almost impossible.

Favorable results from climate can hardly be looked for unless at least \$10 per week can be spent for board and lodging. The stranger, who has spent a large part of his savings on railroad fare, soon finds himself without work, living in the poorest rooms, eating the scantiest and cheapest food.

The practice of advising the removal to other climates thus defeats its own aims and casts upon the charity of other communities a burden which they should not and cannot sustain.

We invite the co-operation of the medical profession, therefore, in preventing persons suffering from tuberculosis from being sent to other states unless:

(a.) They are physically able to work and have secured in advance a definite assurance of the opportunity to perform work of a proper character at wages sufficient for their suitable support; or,

(b) Unless they have at their disposal at least \$250 in addition to railroad fare.

THE COMMITTEE ON THE PREVENTION OF  
TUBERCULOSIS OF THE CHARITY OR-  
GANIZATION SOCIETY.

## DEPARTMENT OF SURGERY.

CONDUCTED BY ANDREW STEWART LOEINGIER, A.B., M.D.

The December *Annals* gives an interesting review of the 1905 German Surgical Congress, excerpts from which are herewith given:

**INTRANEURAL INJECTION OF ANTITOXIN IN THE TREATMENT OF TETANUS:**—Prof. Kuster (Marburg) reported a case. Gumprecht first called attention to tetanus toxins reaching the central nervous system through the peripheral nerves. Meyer and Ransom blocked the nerves and thus protected the spinal cord. Kuster had demonstrated the efficiency of blocking in

the case reported. The patient was an adult employe of the von Behring Institute who had cut his palm on a broken beaker containing virulent tetanus bacilli. The wound was washed with tetanus antitoxin and subcutaneous injections were also given. Seven days later painful spasms of the arm began and were followed by similar conditions in the jaw, neck and esophagus. Kuster exposed the brachial plexus and injected the antitoxin into the median, ulnar and musculospiral nerves until considerable swelling resulted. The cervical nerves

were treated in like manner. Next day the spasms entirely disappeared and never returned but a very painful and long-continued myositis(?) developed within a few days which he did not ascribe to the injections. Perfect recovery resulted. Kuster does not think cord involvement precludes success if the nerves are properly blocked to prevent additional absorption of the toxin. Hertle (Graz) reported a case he had treated in 1904 in a similar manner but with unfavorable result. The injections were given the third day after the symptoms developed, with pronounced improvement at first, but after six days the patient became suddenly worse and died within a few hours. Hertle believed the injection should be repeated a number of times.

Braun (Gottingen) thought the injections were of no benefit once the spasms were established. After ten days no benefit could be derived from intraneural blocking.

Kocher (Berne) reported one case in which recovery followed the use of the injection. He thought favorably of the method but did not believe too much should be expected of it. The antitoxin was probably only able to neutralize the toxins in the peripheral nerves into which it was injected.

Kuster in closing the discussion said that we should limit the use of the method to the first days after the appearance of the symptoms and advised using it as early as possible.

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**PERMANENT RESULTS FROM THE OPERATIVE TREATMENT OF BASEDOWS DISEASE:—** Dr. Friedheim (Hamburg Eppendorf) reported twenty cases operated by Kummel either by enucleation or partial resection of the goitre or partial ligation of the afferent vessels. All had well-marked symptoms as exophthalmos, goitre, palpitation, marked emaciation and usual disturbances of the nervous, respiratory and digestive

systems. All were women. Fourteen recovered after operation. Five were improved. In three cases the symptoms so persisted that a second operation was recommended. One death occurred from tetanus ten days after a secondary operation.

It is considered that the successful cases demonstrated the theory of Mobius, that Basedows disease is due to a morbid hyperactivity of the thyroid gland, causing the clinical symptoms. The most important point to determine is how much of the gland to remove. Too radical excision may precipitate strumapriya symptoms. Too little removed effects no cure. All partially improved cases still showed a goitre. Those cured were free from any tumor. In 1900 Rehn reported 30 per cent. complete recoveries and a mortality of 22 per cent. Kummel's cases showed 70 per cent. recoveries and 5 per cent. mortality. Medication seldom leads to any permanent results. The general mortality is 12 per cent. Surgery gives at least 7 per cent. better statistics.

Kocher (Berne) confirmed Kummel's and Friedheim's observations and believed that the results of surgical treatment is the best proof for the hyperthyroidization theories of the disease. If recurrence takes place the operation should be repeated. Genuine recovery can only be possible after operations. Internal means offer no such results. Early operation gives best results and lowest mortality. Careful estimation of the blood pressure should be made.

**TOXIC ACTION OF SUBLIMATE.—** Bokorny found that minute scraps of algæ were killed or injured by corrosive sublimate even in a 1 to 100 or 1000 million dilution, while a large clump was not much affected by quite strong solutions. The action of sublimate is thus a quantitative chemical reaction. A certain amount of the protoplasm albumin requires a given amount of sublimate to destroy it. This proportion for the spirogyra is about one two-hundredth of its own weight.



## DEPARTMENT OF INTERNAL MEDICINE.

CONDUCTED BY DR. DUDLEY FULTON, LOS ANGELES, CAL.

**THE TREATMENT OF GASTRIC ULCER—PRESENT STATUS OF OPINION.**—In the *Boston Med. and Surg. Jour.*, Sept. 21, 1905, Shattuck presents the medical treatment as he views it as follows: Stomach rest in the severe cases for three or four days during which time nutritive enemata are used. He now advises against prolonged stomach fasting. Milk and other foods which tax the stomach least are then gradually given. Meat is denied three or four months. Bismuth, alkalis, morphine, are administered to control hyperacidity and pain. Surgical treatment is demanded only in cases in which there are: (1) cicatricial contraction at or near the pylorus causing dilatation, (2) perforation.

In regard to surgical intervention in cases of hemorrhage, it seems that it is not often advisable for the reasons that the existence of hemorrhage makes the case an unfavorable one for operation and furthermore, because the mortality of hemorrhage cases is only 2.1 per cent. (Russell.)

Since Shattuck wrote the above article, a symposium on the above subject was presented in the College of Physicians of Philadelphia, in which symposium Drs. Billings and Steele presented the medical features of ulcer of the stomach and Drs. Brewer and Denver, the surgical.

The following conclusions have been reached: Operation for gastric hemorrhage during the hemorrhage is futile, for it is impossible to find the bleeding point, and the operation only serves to increase the shock. A single hemorrhage does not necessarily indicate operation, but repeated hemorrhages indicate operation in the interval, the operation being a gastro-enterostomy to

permit the healing of the ulcer. Cases of undoubted gastric ulcer in which the symptoms persist for a period of from six to ten weeks under competent medical treatment should, as a rule, be subjected to operation.—*Therapeutic Gazette*, Dec., 1905.

\* \* \*

**AN EXPERIMENTAL INVESTIGATION OF THE BUDDE PROCESS FOR THE PRESERVATION OF MILK.**—Hewlett, in *London Lancet*, Jan. 27, 1906, describes this process which is patented by a Danish engineer and is now being extensively applied in Denmark and Sweden, and reports the effectiveness of the process as applied to practical use. The principal of the process is as follows: The milk is obtained as cleanly as possible and effectively chilled in the usual way or treated by the process at once. A proper proportion of peroxide of hydrogen is added to the milk and the mixture is heated to from 51 to 52 degrees C. for at least three hours. With the aid of the heating the hydrogen peroxide is completely decomposed into water and oxygen by an enzyme (catalase) of milk, and the oxygen at the moment of liberation, being in a nascent state, acts as an efficient germicide. By this process no germicide is left in the milk, a small but unappreciable amount of water has been added to the milk, and the majority of the micro-organisms have been destroyed. The milk will keep sweet for at least 8 or 10 days in hot weather. The amount of hydrogen peroxide added to the milk is about 15 c.c. of a 3 per cent. solution per quart of milk.

Hewlett in order to test the efficiency of the process added pure cultures of

various micro-organisms to milk. He reports: "All 'the nonsporing organisms, pathogenic and nonpathogenic, dealt with—viz., the bacillus tuberculosis, the bacillus diphtheriae, bacillus lactici acidi, bacillus typhosus, bacillus coli, bacillus dysenteriae, micrococcus pyogenes aureus and the cholera spirillum—are destroyed by the process. Sporing forms—are not destroyed by the process although reduced in numbers. In milk obtained in the ordinary way without special (as to cleanliness) precautions the micro-organisms are reduced by the Budde process over 99.9 per cent."

\* \* \*

### EARLY CIRRHOSIS OF THE LIVER AND ITS TREATMENT.—

Cirrhosis of the liver is a disease, which because of its frequency and the seriousness of the symptoms which it produces, is of great interest to the clinician. Out of 500 autopsies at the Johns Hopkins Hospital advanced cirrhosis was the cause of death in 10 per cent. of the cases.

Richardson, *New York Med. Record*, Vol. 66, No. 16, in discussing the above subject, says that the cause of cirrhosis, as far as experimental evidence goes, is the absorption of toxins from the alimentary tract formed in perverted digestion and the reduction in the outflow of the bile, which would prevent the elimination of toxins from the liver.

Syphilis and malaria are also causes. They produce excessive hemoglobin destruction, increasing the amount of bilirubin formed, which, if not eliminated by the bile, remains in the circulation, producing the icteroid discoloration of the skin and acting as a toxin.

Alcohol has been accused of producing cirrhosis, but it is probable that it is not the alcohol itself, but the organic toxins which are produced in the perverted digestive processes.

The early manifestations are usually indefinite. This disease occurs in the young and the old, in the abstemious and the glutton, in the alcoholic and the teetotaler. Its manifestations are often paroxysmal in character. Perhaps the most significant early symptoms point to disturbances in the functions of the stomach and intestines, muddy or yellow skin, loss of weight, dilatation of the surface capillaries and later of the abdominal veins, hemorrhoids and tympanites of the abdomen.

*Treatment:* Hepatic cirrhosis is the result of a toxæmia and its treatment must therefore consist in the removal of the cause of the intoxication, with, at the same time, stimulation of the liver so that it may do its part in the oxidation and elimination of the poisonous substances. Attention to gastro-intestinal digestion is of the first importance, as, if the food supply of the body is perverted or reduced, it cannot be expected to recuperate. The elimination of bile should be increased by the administration of sodium glycocholate with the addition of small doses of mercury. The fluidity of the bile can be increased by the administration of alkaline mineral waters with sodium salicylate, which latter drug seems to have some influence in increasing the fluidity of the bile.

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### INFLUENCE OF ALTITUDE ON HEART DISEASE.

—Galli reports two cases of vasomotor neurasthenia of the heart—"irritable heart"—two of aortic insufficiency and one of arteriosclerosis and myocarditis of the Adams-Stokes type, in all of which the patients derived unmistakable benefit from a sojourn among the mountains. The altitude was about 4,000 feet. The patient last mentioned was taken in the family carriage to the upper Engadine, through the passes, at an altitude of more than 7,000 feet. The ascent was made without loitering and a week was spent at this altitude. No ill effects were observed thereafter.—*American Medicine*, March 4, 1905.

# SOUTHERN CALIFORNIA PRACTITIONER

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

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## EDITORIAL.

### DEAN JOSIAH H. PENNIMAN OF THE UNIVERSITY OF PENNSYLVANIA.

The frontispiece for the March issue of the PRACTITIONER is a half-tone of Dr. Josiah H. Penniman of the College of Liberal Arts of Pennsylvania, who spent several days in Los Angeles during the month of January, at which time he addressed the students of the College of Medicine of the University of Southern California, his talk being of very great interest and being illustrated by lantern slides that showed the development of the various departments of the University of Pennsylvania.

Dr. Penniman's visit was made the occasion also of a reunion of Penn graduates, the officers elected by the organization being Dr. Wm. A. Edwards, Medical '81, president; Dr. T. Perceval Gerson, Medical '95, vice-president; Dr. Charles C. Stivers, Medical '01, secretary-treasurer.

Dr. Penniman is not only an educator of note, but is a most delightful gentleman to meet and the PRACTITIONER hopes to present in a subsequent issue the address delivered at the Medical College, so that those who were not so fortunate as to be present may have an opportunity to enjoy it.

### THE SEMI-CENTENNIAL MEETING OF THE MEDICAL SOCIETY OF THE STATE OF CALIFORNIA.

The fiftieth annual meeting—the semi-centennial meeting—of the Medical Society of the State of California will be held at San Francisco on April 17th, 18th and 19th, although operative and medical clinics will be held on Monday the 16th and Friday and Saturday the 20th and 21st, as informal additions to the regular programme. Our San Francisco brethren will endeavor to do themselves proud on this occasion and it is safe to guarantee an enjoyable and



profitable time to all members who attend.

The full programme is not yet ready for publication, but in our next number we hope to print it, along with information regarding rates and other matters of interest.

It is needless to add that it is desirable that California, south of the Tehachepi, should be well represented at this meeting. This we owe not only to our State Society and to ourselves, but to our San Francisco colleagues who are making extra efforts for our proper entertainment.

#### THE COMMITMENT OF THE INSANE.

Under this title is printed in the current number of the *PRACTITIONER* a paper by Dr. A. P. Williamson, which was read by him before the recent annual conference of the California Associated Charities and Corrections which was held in Los Angeles. The paper and the discussion thereon contain some very suggestive thoughts many of which should be of interest to general practitioners, both from professional and humanitarian reasons.

The general proposition that an irresponsible and dangerous person should be placed under conditions where he can do neither himself nor his fellowmen harm is so well established in law and in practice as to need no argument in its favor. It is almost a self-evident proposition. The world, however, is under obligation not to forget that every insane person is a human being; moreover, a human being who may recover from his disease and again be added to the roster of useful citizens of our commonwealth; and as such

an individual his rights as a citizen are to be carefully safe-guarded.

The difficulty of obtaining accurate information concerning the onset of the disease in these patients (which history may play an important part both in diagnosis and treatment); the inadequacy of the commitment papers from the standpoint of scientific medicine; the insufficiency, intentional or unintentional, of many medical examiners of the insane, in the filling in of the question blanks; the manner in which the insane are adjudged to be such in the courts and the legal issues which make such commitments at times the basis of some very complicated medical jurisprudence; the way in which our politicians have kept the charge (and charges, since the "charges" are the crux of the whole matter on this point) of these insane in the hands of sheriffs and their underlings, whose non-intelligent treatment would at times make even a sane individual become maniacal; these and other topics quite as worthy of thought are all touched upon by Dr. Williamson and the other alienists who discussed his paper, and should be profitable and interesting reading, and our only regret is that lack of space prevents our publication of the discussion in its entirety.

Conferences such as that of the Associated Charities and Corrections may be made the means of much mutual and helpful endeavor for those who are entrusted by the State with the care of this group of its unfortunate citizens and the Golden State is the gainer for having within its own confines so unselfish an organization as the California Associated Charities and Corrections.

## A STATE QUARANTINE AGAINST TUBERCULOSIS.

There is one other point in the discussion of Dr. Williamson's paper on the Commitment of the Insane to which we would call attention, which was made by Dr. Hatch, who referred to the state law which requires a person to be a resident of California one year before being eligible to treatment in a state hospital for the insane. (By way of digression, the proposition stated in this form would seem to be privilege every body would be willing to dispense with.)

Last year there were, however, more than 150 persons committed to our state hospital who had been residents of California less than one year and efforts to have the states from which they came assume charge of these persons, were of no avail, the usual reply from the attorneys general of these states being: "Show us proof that the man was insane before he left our state." Such proof is, of course, extremely difficult to obtain.

We refer to this point because it has not been so many moons ago since a bill was before a California legislature, the object of which was to prevent consumptives of other states from entering our own.

Now, if it is difficult and in practice virtually impossible to send recently arrived insane persons back to the commonwealths from whence they came, would not the same legal obstacle be encountered in even worse form, as regards persons afflicted with tuberculosis?

Attention is called to this point because not only is this inhumane and thoroughly impracticable state quar-

antine against consumptives advocated by some laymen, but because, from time to time, it even receives the sanction of some members of the medical profession, whose knowledge of the situation should prevent their countenancing such unnecessary, harsh and at the same time impossible measures.

The tuberculosis problem in our state is one that is worthy of careful consideration, but state quarantine as one of the measures of prevention, should be mentioned only as being worthy of immediate dismissal. To those to whom the inhumane phase of such a measure, or the impossibility of examining for tuberculosis at the state borders all persons who are about to enter the commonwealth, fails to appeal, we commend the point made by Dr. Hatch, that once in the state, it is virtually impossible to make the commonwealth in which the disease was acquired, assume charge of such a diseased person, so that granted that such an inhumane and foolish law were passed it would, for this reason, be thoroughly useless as regards execution.

## THE NEXT CLINICAL MEETING OF THE COUNTY MEDICAL ASSOCIATION.

Through the generosity of the president of the Los Angeles County Medical Association, Dr. F. C. E. Mattison, the next clinical meeting of the Association will be marked by the initiation of the plan of having refreshments at at least one of the monthly meetings of the Society.

Every medical organization should strive for three objects:—one, the scientific development of its members;

two, the promotion of their social relations with one another; and three, the safe-guarding of their material interests.

Our scientific development we have well in hand. The material interests will be attended to in good time. Our social relations with one another, while good, are capable of improvement, and nothing will help bring about this much desired desideratum so greatly as the practice of occasionally breaking bread with one another.

At this first attempt at a buffet lunch at the clinical meeting of March, the Association's members are virtually the guests of the President, since he will defray the expenses.

It is to be hoped that the attendance will be so good, and the informal lunch so successful, that the sentiment for the continuation thereof will be so general that the Board of Trustees will feel justified in putting aside a sum of money, by means of which these refreshment features may be kept up.

Once fairly tested, we are sure their benefits will become so manifest that no one will ever suggest their discontinuance, even if, through lack of funds in the treasury, it should become necessary to declare a special assessment at each such meeting.

We are sure that the plan will rebound to the best interests of the profession as a whole, and whatever works for that end, is worthy of consideration, trial and of our aid—even though some features of the plan be not to our individual liking.

### THE PASSING OF BERIBERI.

Apropos of Dr. Barlow's interesting editorial on beriberi and report of a case at the County Hospital, which was published in the January number of the *PRACTITIONER*, the *Journal of the A. M. A.* of February 17th, page 518, stated that Baron Takaki, Surgeon-General of the Imperial Japanese Navy, at the dinner tendered him by the Senn Club of Chicago the week previous, had expressed his conviction that the reason beriberi had practically disappeared from the list of diseases in the Japanese Navy, whereas in 1872, when he entered the service, it was responsible for three-fourths of the morbidity, was due largely to the fact that the carbohydrate food principles which had formed an excessive part of the dietary of the sailors, had been in good part supplanted by albuminous foods.

It is also worthy of note that Baron Takaki was successful in inducing this change in diet, only after years of strenuous endeavor directed against the line officers and men who thought they knew more about dietetics than he did.

Baron Takaki's action was based on a careful study of the causes that might be responsible for this dread disease and while it is true that other factors may enter into its etiology, the results obtained through the adoption of his recommendations as to diet show that the disease may be entirely prevented, no matter what the exact causative factors may be.

### AN OBSTETRICAL SECTION OF THE COUNTY MEDICAL ASSOCIATION.

Upon the suggestion of the Council of the Los Angeles County Medical



Association, there was organized on February 23rd, a new branch of the Association, to be known as the Obstetrical Section. There was a very good attendance present and the organization was completed by the election of Dr. M. L. Moore as chairman, Dr. J. H. Seymour as clerk and Dr. Titian Coffey as councilor. A committee of three was also appointed to draft a constitution and by-laws.

This Section will commence its work with a roll of more than thirty active members, all the meetings, however, being open to all members of the County Association. The officers of the Section are desirous of having all practitioners who do obstetrical work become associated with the Section as active members.

It should be gratifying to the profession of Los Angeles to note these continued evidences of activity along the lines of organization. To differentiate the various phases of our scientific work through the establishment of sections in the specialties is to our mind an advantage, since it places the scientific work of the Association along such lines, in charge of those members who are most interested in those particular fields. Under the genial leadership of Dr. M. L. Moore we predict a successful career for this new Section, which because of its nature, should have a large enrollment.

As time demonstrates its value, as has already been done for the Eye, Ear, Nose and Throat Section, the way will be indicated, no doubt, for the development of other branches. Every such forward advance may be construed as

making for better things in the local profession, and as being worthy on that account, of hearty support.

#### THE NATIONAL ASSOCIATION FOR THE STUDY AND PREVENTION OF TUBERCULOSIS.

The transactions of the first annual meeting of the National Association for the Study and Prevention of Tuberculosis which have recently been distributed to its members in bound form, contain the reports of committees, and two score papers which were read at the meeting, the whole making a handsome volume of four hundred and eighty pages.

The constitution and by-laws of the Association are printed under separate cover and the geographical list of the membership credits Los Angeles with ten out of the eighteen California members, the Los Angeles contingent consisting of Doctors W. Jarvis Barlow, Norman Bridge, Charles C. Browning, J. O. Cobb, George L. Cole, George H. Kress, F. M. Pottenger and Messrs. J. F. Barnard, Joseph H. Johnson and A. G. Wells.

Los Angeles was honored in being represented on the Board of Directors of the Association by Dr. Norman Bridge, who was also the chairman of the Clinical and Climatological Section, one of the papers of this Section, entitled "Impalpable Sputum, as a Usually Overlooked Danger in Tuberculosis," being read by him.

In this paper Dr. Bridge directed attention to the droplet infection of Flugge and stated that it was to be feared, since the palpable or tangible sputum of consumptives was recognized

even by patients as a nasty and dangerous element worthy of destruction; whereas they were nearly always ignorant of the existence of this impalpable sputum, as well as of the frequency and ease with which they could, in speaking and coughing, throw off myriads of bacilli that could be directly breathed by companions, or indirectly inhaled after having dried into dust and infecting personal clothing or the furnishings of a room.

This "insidious, smokeless powder peril of the race" was worthy of earnest attention in the anti-tuberculosis crusade. The difficulty of reaching this peril was pointed out and means suggested whereby its destruction could be accomplished with the greatest economy and ease.

The new officers of the association for the current year are: President, Dr. Hermann B. Biggs; Honorary Vice-President, Dr. William Osler; Vice-Presidents, Dr. Lawrence F. Flick and Dr. Vincent Y. Bowditch; Treasurer, Gen. George M. Sternberg; Secretary, Dr. Henry Barton Jacobs.

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#### THE PASADENA BRANCH OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.

Last month it was our privilege to attend the meeting of the Pasadena Branch of the Los Angeles County Medical Association and the proceedings were of interest to us for a number of reasons. Not only because of the interesting scientific programme—this was a clinical meeting and nearly all the members took part in the presentation of cases or specimens and in the discussions—but more especially because of

the nature of some of the business that came before the Branch.

The suggestion was made that it would be a great convenience and an economy as well, if the members who had automobiles would club together to hire a barn and man to look after their machines. This suggestion was put on the way to realization by the appointment of a committee to look into the project and to report at the next meeting. The members who were not so fortunate (or unfortunate) as to own automobiles, in no manner objected to the effort of their colleagues, who were striving to break the bands or bonds that fastened them to the garage owners, although one member did suggest that the Pasadena Medical Garage once established, the next step would be to establish the Pasadena Medical Blacksmith Shop for members who still cling to the horse, and a Shoemaker's Shop for other members who visited their patients afoot. These latter suggestions, however, were made in a spirit of fun at the expense of the automobile members whose purses seemed unable to stand the drain of garage repairs.

Another item of business transacted was the decision to have a clinical and operative meeting about once every three months at the Pasadena Hospital.

The above motions are specifically mentioned because they are somewhat out of the routine trend of medical association work and they are particularly worthy of notice because they show how potent a factor good fellowship may become in the upbuilding of the scientific, material and social interests of the profession.

### A DESERVED HONOR.

An honor, which to our mind was well bestowed was that which recently came from the American Association for the Advancement of Science to Lyman Brumbaugh Stookey, Ph.D., professor of physiology in the College of Medicine of the University of Southern California.

Dr. Stookey, who, after his under and post graduate courses at home, spent several years at the University of Strassburg in Germany, has done some researches in physiological chemistry that are of considerable merit and note. One of these, by the way, entitled "*Zur Kenntnis der Eiweisspeptone*" (Aus dem physiologisch-chemischen Institute in Strassburg) was recently printed in "*Beiträge zur Chemischen Physiologie und Pathologie*" (Zeitschrift für die gesamte Biochemie), Band VII, Heft 12. Dr. Stookey is carrying on additional investigations along these lines in the College of Medicine and the PRACTITIONER hopes at some future time to print a resumé of these researches.

The American Association for the Advancement of Science is what its name implies, an organization of professional and other scientists who have at heart the advancement of science and contains among its roll of members many of the leading investigators and teachers in this country. Membership therein is esteemed an honor, but a much greater honor than mere membership, is the election as a Fellow of the American Association for the Advancement of Science. Such fellowships are only voted by the Council of the

Association as an evidence of the meritorious opinion which the Association holds of the scientific work or researches of the persons so honored.

Dr. Stookey's election in January last, as a Fellow, came to him as a surprise and is a token of the manner in which those who are in an excellent position to know, feel towards the research work he has already brought forth. We congratulate him and feel that the honor which has come to him as an individual, is reflected upon the college with which he is connected, and on the community in which it is placed.

### THE SAN FRANCISCO COUNTY MEDICAL SOCIETY IS SITTING UP AND TAKING NOTICE.

This is perhaps, not a very elegant manner in which to call attention to the following item (italics our own), clipped from the March *California State Journal*, page 109:

"Dr. Philip M. Jones made the suggestion that the scientific meetings of the San Francisco County Medical Society come more often than once a month, stating that the *Los Angeles Society* now had scientific meetings every week.

"Dr. Jones made a motion that the Chair appoint a special committee of three to consider the plan of weekly meetings for this Society and present their considerations to the Board of Directors. This motion was seconded and carried."

The Los Angeles County Medical Association is to be commended for having been the first county medical organization in California to have inaugurated weekly meetings and it is pleasant to know that the beneficent effects of this practice are already becoming manifest, both at home and abroad.

In large centers of population such as San Francisco and Los Angeles, there



is no rational reason why weekly meetings should not be in the accepted order of things. The establishment of the practice, other than the good that will directly accrue to those societies and their members, cannot but be reflected with excellent results on county medical organization work throughout all parts of the State.

Los Angeles, in the best spirit of fellowship, congratulates its sister city of the Golden Gate, on this forward step.

### THE WORM DOCTOR FAKE.

An article on this subject, from the pen of Dr. A. Davidson of Los Angeles, in which he gave an exposé of a widely advertised "worm doctor" of this State who is in the habit of presenting such patients as become his victims, with specimens of the larvae of *musca domestica* (the common house fly) as being some of the worms that had been passed as the result of treatment, was printed in the January number of the PRACTITIONER and has brought the following interesting personal note from our friend, Dr. John C. King, of Banning, which we take the liberty, though not without some misgivings, of reproducing in full:

"BANNING, CAL., Jan. 30, 1906.

"Dear Doctor:

"Anent Dr. Davidson's report on the 'Worm Doctor Fake' permit me to duplicate his experience. A few months ago a young lady patient of mine was taken by her parents to the fakir. The routine described by Dr. Davidson was pursued. *Result:* A vessel full of worms. One of my Banning medical friends was intimate with the girl's parents and had been invited to witness the 'seance.' He rescued a portion of the worms in an empty pill box and brought them to me. Samples were sent to the department of entomology of

Stanford University and identified as larvae of *musca domestica*. My friend succeeded in hatching one specimen. The young lady made an uninterrupted recovery; gratitude for which impels her to send her friends, when 'King can't cure 'em,' to the genial worm doctor. The number of maggots supposedly contributed by Banning to that gentleman's *pot de chambre* would convey the impression that we are a pretty rotten community.

"Respectfully,

"JOHN C. KING."

The PRACTITIONER is of the opinion that Drs. Davidson and King have done the community a good service in calling the attention of the profession to fakirs of this class. It is to be regretted that our laws are not such as would prevent the operations of charlatans of this worm-doctor stripe.

### THE MEAT SUPPLY OF LOS ANGELES.

For several years, Dr. L. M. Powers, Health Officer of Los Angeles, has called attention to the need of more careful inspection of the meat supplies of the city and has urgently requested the establishment of a slaughter-house district, so that all meat brought to Los Angeles for consumption might be inspected, both upon the hoof and in the refrigerators, before being killed or offered for sale and consumption.

Under the present system it is utterly impossible for either local health officials or government inspectors to exercise proper supervision and control over the many slaughtering establishments scattered in the different parts of the city. These slaughtering establishments, many of them, are unsanitary and the owners of some of them are not above suspicion as regards killing and offering for sale the meat of diseased animals.

Such a state of affairs is decidedly in opposition to what should exist. No one desires to eat the meat of diseased cattle. And yet from reliable accounts such things have happened in Los Angeles and the present lax system makes its entire prevention quite out of the question.

The fact that all meats are subjected to heat and high temperatures before being placed on the table, and the further fact that it is a food principle not consumed by infants, makes the danger from diseased meats compara-

tively less, of course, than from contaminated milk, but this does not lessen the natural repugnance that one has against partaking of such foods.

It is curious that Dr. Powers' efforts to bring about a better surveillance of the meat supplies of the city have been so persistently blocked and the question naturally arises as to whether or not the Committee on Public Health of the County Medical Association might not be able to aid him. It would certainly seem to be a question worthy of consideration.

## EDITORIAL NOTES.

Dr. Wm. C. Mabry has located in Cannanea, Mexico.

Dr. J. H. Lacy, of Solomonville, Ariz., has been visiting Los Angeles.

Dr. J. P. Welch has located in Cottonwood, Ariz.

Dr. J. R. Lynn, of Roswell, N. M., recently spent a few days in El Paso.

Dr. George A. Harker has located in Santa Barbara, Cal.

Dr. S. Y. Ketcham, of Escondido, Lower California, has been spending a few days in Southern California.

Dr. C. B. Bates, the well-known physician of Santa Barbara, has been spending a few days in San Francisco.

Dr. W. G. Shadrach of Albuquerque was recently called professionally to Chicago.

Dr. Aquin S. Kelly, formerly of New York City, has recently located in Santa Barbara, Cal.

Dr. A. M. Tuthill of Morenci, Ariz., was recently called professionally to New York City.

Dr. Thomas M. Michaels was recently appointed postmaster at Egris, New Mexico.

Dr. John Roger Haynes, of El Vado, New Mexico, has been spending a few days in Albuquerque.

Dr. W. V. Marshburn of Whittier graduated from the medical department of the University of Louisville in 1886.

Dr. E. A. Hall, of Prescott, Ariz., recently received his license from the Territorial Board.

Dr. T. F. Beveridge, of Muscatine, Iowa, has been spending a few weeks in Southern California.

Dr. Norman Bridge has been in Mexico looking after extensive and valuable mining interests.

Dr. Edward T. Dillon of Los Angeles, who has been quite ill, is now convalescing.

Dr. Geo. P. Luton, graduate of Trinity University, Canada, has located in Los Alamos, in Santa Barbara county.

Dr. James A. Massie, of Santa Fe, has been appointed a member of the Territorial Board of Health, vice Dr. J. H. Sloan, resigned.

Dr. W. D. Groton, of Rivera, Cal., graduated from the University of Mary-

land in 1879, and has been practicing in Rivera for twenty years.

Dr. S. R. Ketcham, of Redlands, has recently been at his former home, Philadelphia, looking after certain business interests.

Dr. C. W. Murphy, of Los Angeles, was recently called to Prescott, Ariz., to perform several surgical operations, and while there was the guest of the profession of Prescott at a banquet.

Dr. George Ryerson Fowler, the noted surgeon of Brooklyn, recently died in Albany, N. Y., after being operated for appendicitis by Dr. Albert Vander Veer.

Dr. J. W. Maertins, physician to the Grant Brothers' Construction Company on the Belen cut-off, New Mexico, has recently been visiting friends in Los Angeles.

Dr. John R. Haynes, who for several years has been a member of the Civil Service Commission, was recently elected president, succeeding Dr. D. W. Edelman, whose term had expired.

Dr. H. F. Scudder, formerly demonstrator of anatomy of the Eclectic Medical Institute of Cincinnati, has located in Long Beach, Cal., where he has associated himself with Dr. L. A. Perce.

The dog poisoner is now abroad in Los Angeles. Dr. R. Wernigk recently lost a Collie worth over \$1000.00. Detectives are at work on the case, and the doctor hopes to discover who the miscreant is.

Dr. C. H. Connor, of Albuquerque, who has been dangerously ill with typhoid fever for some months, having suffered a serious relapse, is now convalescing and has gone to Phoenix to recuperate.

Dr. Merritt Hitt of Los Angeles has been quite ill at the Good Samaritan Hospital. We are glad to say that he is recovering. During his incapacity Dr. W. W. Richardson had charge of his practice.

Dr. W. R. Tipton, of Las Vegas, N. M., has resigned as superintendent of the New Mexico Insane Asylum at that city. The doctor had held that position many years, and is succeeded by Dr. A. W. Smith.

Dr. F. K. Ainsworth, chief surgeon of the medical department of the Southern Pacific system, has been in Arizona and New Mexico on a regular trip of inspection. While there he established an emergency station at Lordsburg.

Mr. Philip Kitchin, who for the past six years has been cashier and assistant manager in the California Hospital, Los Angeles, has recently been appointed cashier of the Mercantile Trust and Savings Bank, corner of Broadway and Mercantile Place.

Dr. N. K. Foster, secretary of the State Board of Health, states that all the sewage of San Francisco and Oakland is swept over the oyster beds along the shore of the bay. This condition shows the great danger of eating the bivalves raised there.

Dr. Edith J. Claypole, of Pasadena, has consented to act as medical adviser for the girl's basket ball team of the Pasadena High School. Dr. Claypole has made a thorough examination of each aspirant for basket ball honors, and is delivering a series of lectures on hygiene.

Drs. F. C. E. Mattison, Stanley Black, and Geo. E. Abbott, are considering the good of the schools of Pasadena, and proposing to recommend regular athletics in all the schools, and that all candidates for admission to school athletic contests must be examined by a physician.

There has been quite an excitement in the medical ranks of Pasadena owing to Dr. W. A. Cundy, an eye and ear specialist having received a twenty-five thousand dollar fee. The other members of the profession seem to think that it was exorbitant. Dr. Cundy expresses the opinion that it was all right.



At a recent meeting of the Santa Barbara County Medical Society, Dr. Philip Mills Jones addressed them. One subject that he presented was: "The advantages derived from each medical association having a press committee that shall keep the daily newspapers correctly informed on matters of importance that come under their line of work."

Dr. George Dock, Professor of Medicine in the University of Michigan, certainly leads a very active, scientific life. We have recently received the following four valuable reprints: "A Case of Infantile Scurvy;" "Methods, Value and Limitations of the Knowledge of the Gastric Contents;" "Professor F. Blochmann's Work on Accidental Vaccination;" "Sphygmograms from Two Cases of Bradycardia."

We have received notices of the marriage of Henry C. Marxmiller, M.D., of Newport, Ky., and Ednah Tinker Crowell, of Los Angeles, on February 22nd, at Bluffton, Ind. Mrs. Marxmiller is one of the most popular young ladies of the city of Los Angeles, and is also a very fine musician. We wish the young couple all happiness, and are glad to learn that there is probability of them making their home in Los Angeles.

The *Los Angeles Times* says: "The daily surgical clinics of the college of medicine, University of Southern California, held from 1 to 2 o'clock in the college clinical building on Buena Vista street, are in charge of Dr. Lemoyne Wills, who has just returned from the European hospitals, full of enthusiasm for the work of relieving suffering humanity. Daily Dr. Wills may be found at the Buena Vista-street clinic, working as assiduously over the indigent sufferers as though he were treating the case of a millionaire.

The hospital car which Dr. Ainsworth designed has attracted the attention of the profession and of railroad men all

over the civilized world. This car can be made to accommodate fifteen patients. There is a dispensary, operating room, state room for the chief surgeon, kitchen, and all the usual accessories. When not in use the ward can be turned into a sitting room. The berths are under the floor of the car, and are raised for use by turning a crank. Dr. Ainsworth proposes to have seven more of these cars built for his company.

Dr. Simon Baruch of New York City has recently been visiting in Los Angeles. He was a guest at the home of Dr. W. Jarvis Barlow. Dr. Baruch delivered a very interesting address to the student body of the College of Medicine of the University of Southern California. The doctor has been spending a few weeks at Paso Robles, and also paid a visit to the Arrowhead Hot Springs. He says: "I have seen nowhere in the world so perfect an equipment for the treatment of disease with water, mineral springs or mud baths, as I have found in the west."

Dr. Charles Terril Simpson, M.D., died in Cananea, Mexico, on February 18th at the age of fifty-three. The cause of death was pneumonia. Dr. Simpson had been a resident of Cananea since February, 1902. Despite the fact that he was very ill the doctor refused to give up his duties until the Thursday before the Sunday on which he died. The funeral services were held in the Y. M. C. A. Hall on Monday at 2 o'clock. He was born in Alabama, and graduated with high honors from the State Medical College of Alabama. He also took post-graduate courses at the Johns Hopkins and the University of Pennsylvania.

Without comment, we print the following paragraph from an editorial in the *Los Angeles Times* of March 2nd, bearing on the San Francisco pugilistic encounter, as a result of which prize-fighter Tenny lost his life:

"It must be remembered that pugilism, in the public's eye, no longer occupies the low, vulgar plane that it did in the old days of Sayre and Heean, Ned O'Baldwin, Jem Mace and those of that ilk. It is now, instead, the pet fad of men who are of our best society—lawyers, doctors, merchants and even the dilettanti and club men. When the gladiators of the prize ring now step into the roped arena, stripped to the belt for battle, it is not a drunken mob of low-browed peasantry they face in audience, but the sleek and scented gentry of the land."

In connection with an editorial in this issue of the PRACTITIONER, referring to worm-doctor fakirs, we print the following item clipped from the *Los Angeles Times* of March 3rd, which appeared under the heading, "QUIRS COURT TO MARRY." "*Groom Must Leave the Country.*" The item itself reads as follows:

"M. O. Yglesias, who was arrested on an insanity complaint and remanded for one week to the county hospital to see how things would turn out, is to return to Mexico.

"Yglesias and a man who passed for his brother came here and opened a place on Main street, where they advertised themselves as worm specialists. The brothers had a quarrel, there was a scuffle and one was shot and killed by the other. Then it developed that the men were not brothers, but that the real name of the dead man was Gomez. Yglesias was tried on the capital charge and acquitted.

"Yglesias is said to have lived on Albany street with a young woman named Miss Carmen Yturios, who passed as his wife. At times he drank heavily and then he acted as if insane. At the county hospital he improved somewhat. Yesterday Judge Gibbs asked Yglesias if he was willing to return to his folks in Mexico. He said that he was willing, and then the court instructed Miss Yturios that she could receive Yglesias at the county hospital when ready to take train for Mexico. It then came out that a marriage was pending and Judge Gibbs told the woman to go with her husband to be and an adjournment was taken to the marriage bureau where a license was obtained and Chaplain Irwin was summoned and tied the knot."

## CORRESPONDENCE.

### LOS ANGELES CHRISTIAN SCIENTISTS REPLY TO THE BISHOP OF LONDON.

LOS ANGELES, CAL., Feb. 15, 1906.

To the Editor, SOUTHERN CALIFORNIA PRACTITIONER:

DEAR SIR.—In your issue of January appears an article entitled, "Christian Science as Seen by an English Bishop," and, as usual, when non-scientists attempt to explain Christian Science, the result clearly shows their ignorance of the subject.

The bishop is quoted as saying: "In Christian Science you are erecting deliberately a real truth into a gigantic heresy." By simple analysis this charge is instantly seen to be false. Heresy, according to the Standard dictionary, is "A denial of some fundamental doctrine of Christianity," and yet Christian Science brings forth proof of true

Christianity as established by Jesus Christ, who said, "these signs shall follow them that believe," and these signs include the healing of the sick as well as the reclaiming of the sinner. If the ability to heal the sick is proof of our understanding of Christianity what is to be said of the bishop's belief that does not confer this ability?

True belief will fulfill the Master's promise—"The works that I do shall ye do also."

The bishop admits that the clergy ought to do healing, but points out that this work should be done in conjunction with the medical profession. This, also, is at variance with the teaching and practice of Jesus Christ, and furthermore how shall one proceed to labor together with the physician who has frankly confessed his inability to do more for the patient?

The healing performed by Jesus and His disciples was such that no human agency could have reached, and so it is now in the practice of Christian Science, as few will seek its help until they have exhausted the skill of the physicians.

The Christian Scientists do not wish to decry the efforts of the physicians, as they are well aware what a noble, disinterested class of men and women

our followers of materia medica are, but they do feel that the method of Jesus Christ is superior to any human system of healing, and this conviction is justified by the healing of disease pronounced incurable by materia medica.

W. E. Brown,

Assistant Christian Science Publication Committee.

## SOCIETY TRANSACTIONS.

### LOS ANGELES COUNTY MEDICAL ASSOCIATION.

#### DIRECTORY.

The Los Angeles County Medical Association meets every Friday evening at eight o'clock in the Art Hall of the Blanchard Building, 233 South Broadway. (Home Phone, Exchange 83.)

One meeting of each month is designated a clinical evening. Members who can present case reports, specimens or patients for this meeting are urgently requested to notify the Secretary or President.

Members who have in preparation, papers that would be of interest to the Association, should notify the Secretary or President, so that they may be placed on the programmes.

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The officers of the Association to whom communications bearing on their respective work, may be sent, are as follows:

President—Fitch C. E. Mattison, Stowell Building, Pasadena.

Vice Presidents—Adelbert Fenyes, Frank W. Thomas, W. W. Murphy, Homer O. Bates.

Secretary—Raymond G. Taylor, Bradbury Building, Los Angeles.

Treasurer—John C. Ferbert, Bradbury Building, Los Angeles.

Councilors—E. W. Fleming, W. Jarvis Barlow, C. G. Stivers, W. W. Beckett, Rose T. Bullard, B. F. Church, J. M. King, R. G. Taylor, L. S. Thorpe, F. C. E. Mattison, Frank Garcelon, George L. Cole, Claire W. Murphy, Stanley P. Black.

Trustees—Walter Lindley, J. M. King, R. G. Taylor, F. D. Bullard, J. H. Seymour.

Membership Committee—L. M. Powers, chairman; W. D. Babcock, E. R. Smith.

Medico-Legal Committee—Lewis S. Thorpe, chairman; William M. Lewis, Adelbert Fenyes.

Legal Committee—Albert Sniland, chairman; Frank D. Bullard, Adelbert Fenyes.

Committee on Public Health—W. W. Becket, George L. Cole, Stanley P. Black.

Pasadena Branch—Adelbert Fenyes, chairman; J. E. Jones, clerk.

Pomona Branch—F. Thomas, chairman; G. G. Toland, clerk.

Long Beach Branch—Homer O. Bates, chairman; J. M. Holden, clerk.

Los Angeles Eye, Ear, Nose and Throat Branch—W. W. Murphy, chairman; Hill Hastings, clerk.



## NEWS ITEMS.

The Pomona branch met on Friday, Feb. 9th, 1906, at the residence of E. C. Bechowsky, the program being as follows:

Diet in Disease—Dr. S. W. Thomas.

A Labor Case Complicated by Acute Intestinal Obstruction—Dr. J. K. Swindt.

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The dues for 1906 are now payable. Members are requested to remit to the Secretary as soon as possible. Make your checks for \$5.00. The attention of members is called to Article X of the Constitution. All members who fail to pay their dues before March 1st will stand suspended.

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Practitioners who have recently been elected to membership in the Los Angeles County Medical Association include:

Los Angeles—Dr. Sherwin Gibbons, Dr. Paul A. Adams, Dr. Joseph B. Tanner, Dr. C. W. Bonyng.

Norwalk—Dr. C. O. Waterman.

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THE EYE, EAR, NOSE AND THROAT SECTION of the County Medical Society met Monday evening, Feb. 5, at 8 o'clock, in the offices of Drs. Ellis and Bullard, 245 Bradbury Building.

The following members were present: Dr. W. W. Murphy, chairman; Drs. Ellis, Bullard, Macleish, Babcock, Church, Kelsey, Kiefer, Dilworth, F. W. Miller, R. W. Miller, and Hastings. Dr. Turner was present as a visitor of the Section.

Dr. Church presented a case of *trachoma*, of interest because of the fact that, as the patient had never been outside of California, the disease must have been contracted here from some case imported; also there had been several relapses of the disease in this case.

Dr. Ellis showed an *improved electric headlight*, devised by a local electrician and convenient for ear and throat operative work.

Dr. Bullard demonstrated, with a patient, an *improved stigmatometer*, made by F. A. Hardy and Company. He said he had used the instrument in many cases and believed it was of advantage in determining accurately the astigmatism, both lenticular and corneal.

The discussion on astigmatism was opened by Dr. W. F. Miller. He referred to Gould's theory of the lid pressure being a factor in the production of astigmatism; also that a serious illness changed the amount of astigmatism likely due to weakness of the ciliary muscle. Dr. Macleish believed that the lid contraction is the result and not the cause of astigmatism; also that the instrument does not measure the correction closer than a quarter; that our efforts should be correct to one eighth.

Dr. Ellis found the instrument of value. Finer degree of correction is often necessary in addition.

Dr. Kiefer referred to influence of rheumatism on astigmatism and the headaches from this cause.

Dr. Kelsey referred to lid pressure and cited his own case where pressure of the fingers on the eyeball would improve vision temporarily when looking intently at an object.

Dr. Church said pressure was of interest as a causative factor and wondered if a difference in the eyes could be found to exist in men who did much shooting where one eye was forcibly shut most of the time.

Dr. Murphy said in an examination of 1500 railroad men astigmatism against the rule existed in the majority.

Dr. Babcock found Verhoff's card of service.

Dr. Macleish wished to bring out the point that as we examine eyes at rest, we must make allowance for a difference in the astigmatism that may occur on use of the eyes from muscular action, etc.

Dr. Bullard closed the discussion.

The membership committee reported favorably on the application of Dr. Kiefer; voted on and passed.

Dr. Babcock, chairman of entertainment committee, reported on the dinner given to those attending the Pacific Coast Section of the American Otolaryngological Society, which met here Jan. 27. The expenditure of \$42.50 for this event was approved.

Dr. F. W. Miller introduced the following amendment to the by-laws of the Section, relating to voting on new members. Section 3, Art. III to be amended to read: "The application, having been recommended by the executive committee at one regular meeting of the society, shall be voted on at the next regular meeting of the society."

The amendment was approved by majority vote, and according to the by-laws, was laid on the table to be voted on at the next regular meeting.

#### MEETING OF FEBRUARY 9.

Dr. WM. A. EDWARDS read the first paper of the evening, entitled "*Sarcoma of the Ovary in Childhood. With a Case.*"

The essayist stated that diseases of the female genitalia in childhood were far more frequent than was generally supposed. Recently an attempt had been made by Howard Kelly and the essayist to collect the cases scattered through the literature, although the incomplete data concerning many cases made this quite difficult. It was an interesting fact that all the diseases of the adult female pelvis had been found in children.

Sarcoma and dermoids were usually found under the third year, while ovarian cysts were more numerous after puberty. Carcinoma has also been found in the earlier years of life. References to the literature show that malignant disease of the ovary in childhood was by no means rare. The symptomatology of these growths is often

very indefinite and operative measures offer a poorer prognosis than in the adult, but often they react better than one would expect. The enlargement of the abdomen is often the first symptom to attract attention. Gynecological examinations in children are difficult and should be done under anaesthesia, and Kelly's technique therefore was suggested. If necessary it may be followed by exploratory incision.

Abnormal pelvic conditions in a child are always to be looked upon with distrust since we may have to deal with a dermoid cyst, sarcoma or adeno-carcinoma of the ovaries, malignant or cystic disease in the kidneys. The various conditions met with were described by the essayist in detail and the case-history of the essayist's patient, a girl of eleven with vague symptoms and signs in whom a large sarcoma of the right ovary was found, was given. The operation performed was right salpingo-oophorectomy and the child made an eventful recovery therefrom, but a recurrence was noted about four weeks after operation and in six more weeks the child had died from extreme metastatic involvement, post-mortem examination showing that no structure in the abdomen had escaped.

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#### DISCUSSION OF DR. WM. A. EDWARDS' PAPER.

DR. JOSEPH KURTZ:—Dr. Edwards' paper deals with conditions which most of us only rarely see. I have had the good luck, or if you will, the bad luck, to have seen two cases. Both were kidney tumors. In the one child there was a large tumor, no ascites, considerable emaciation, and child only complained of discomfort. The tumor mass was thought to be a sarcoma, but Dr. Stanley Black, who made the microscopic examination, reported it to be a carcinoma. This patient died within twenty-four hours after the operation. The other case was one of sarcoma, the patient dying later from recurrence, after operation.

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DR. E. FOLLANSBEE:—Personally had no direct knowledge of sarcoma and carcinoma in infants, but recalled a case of hernia of the ovary, a condition that had been mentioned by Dr. Edwards. An infant of 10 weeks was brought to Dr. Follansbee for a digestive dis-

turbance and was treated therefore. Two days later father brought the child and stated that the child had a hernia, which he had always been able to reduce up to that morning. Physical examination showed it to be no ordinary hernia, but not one of several physicians who saw the child at the old California Hospital made the diagnosis of a hernia of the ovary, and that was what was found by Dr. Beckett when he operated. Child made a good recovery and was living up to several years ago.

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DR. W. W. RICHARDSON read a paper entitled "*The Treatment of Fractures*," which will be printed in a subsequent issue of the PRACTITIONER.

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#### MEETING OF FEBRUARY 16.

DR. E. M. LAZARD presented a patient on whom *A Skin Grafting of an Avulsed Scalp* had been done and gave the following case-history:

The patient whom I have the pleasure to present this evening is a factory operator, the one who had her scalp torn from her head on the 27th of last September. She was stooping down close to a 2-in. shaft which was revolving about 100 times a minute. Her hair was caught in the shaft and the scalp was torn from her head and becoming wrapped around the shaft it was necessary to back up the shaft in order to release the torn scalp and hair from it, after which the scalp was replaced on the head. This was done by the foreman of the factory, and when I first saw the patient I found her pulseless at both wrists and in a condition of extreme shock. Hastily wrapping a bandage around her head I gave her strychn. sulph. gr. 1-30 by hypodermic, and removed her immediately to the Emergency and General Hospital. There with the patient under an anesthetic administered by Dr. Claire and assisted by Dr. Keyes, I shaved the hair from the scalp, cleaned the wound and sutured the scalp in place. I found the tear extending from just

above the tragus of the left ear, around through the eyebrow line just above the right ear down on to the neck and close to the base of the skull across to within about three inches of the left ear. The scalp was peeled back off the skull and was torn in irregular manner transversely and sagittally in the occipital region. After thoroughly cleansing the wound, we sutured it in place taking between 95 and 100 sutures to close the and 100 sutures to close the wound. Drainage was provided through a transverse tear just below the occiput.

During the operation the patient received one quart of normal salt solution with adrenalin chloride 1-10000 subcutaneously. She reacted from the shock of the operation very nicely. The extent of the wound and the separation of the flap of the scalp from its nutrition gave a very poor prognosis as to the life of the scalp.

The convalescence of the patient was uneventful. The temperature never being higher than 100.6. There was no infection. The scalp tissue, however, necrosed to a great extent. About one-fourth of the left side of the scalp only living. The greater part of the thickness of the scalp lived, only epidermis necrosing, except in the right parietal region where the bone had been laid bare. Here the entire scalp necrosed.

On the 17th of November the exposed portion of the bone having granulated over, assisted by Dr. Taylor, I skin-grafted the granulating wound with Thiersch grafts taken from the patient's thigh. We could not, however, get sufficient skin to cover in the entire surface at one operation, so the posterior portion of the wound was left for a subsequent operation. The grafts all took well and the patient's temperature, which up to this time had been fluctuating from 98 to 99½ to 100, from this time remained normal.

The grafted area was kept dressed with normal salt solution for one week,



after which the grafts having taken well, they were dressed dry with periform gauze.

The area between the grafts rapidly epithelialized over, so that on the 8th of December we were able to do a second operation covering in the balance of the granulated area. Under the same dressing as before, this took equally. After about three weeks, however, small areas of the skin broke down, probably due to contraction of the older granulations shutting off the nutrition. This has now almost entirely healed over, and I think we have every reason to hope that the patient will have no further trouble from this source.

After the healing is completed and the new skin is sufficiently tough to bear the weight, the patient will be provided with a wig which will cover up practically all of the scarred area, so that there will be little evidence of the accident through which she has gone.

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#### DISCUSSION OF DR. LAZARD'S PAPER.

DR. PAUL ADAMS:—Inquired as to extent of pedicle by which scalp was held to neck. Citing a case from Brooklyn Hospital. Here the entire scalp had been torn completely off, the line of tear being similar to that of Dr. Lazard's patient. Ambulance surgeon had failed to bring in the scalp and was sent back for it. It was cleansed and sutured but sloughed. Patient was skin grafted eight different times. Grafting was very difficult because it had to be done on the bone almost. All kinds of grafts were made. Inquired as to treatment of the grafts.

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DR. E. M. LAZARD:—The pedicle was about two inches wide. Found moist dressing over the grafts valuable until they had taken; but after that the dry dressings were better, as the moist dressing caused too much maceration.

DR. ROSS MOORE presented two cases, one of *Tabes Dorsalis* involving the lower extremities, and one of probable *Inseminated Sclerosis*, and contrasted the clinical history and symptoms, showing the dissimilarity between the tactile sense, knee jerks, ankle clonus, bladder symptoms, pupils and general ocular conditions, ability to stand with eyes shut, etc.

These cases were discussed by Drs. Black, Adams and Fulton during which the differential diagnosis between the two cases was thoroughly brought out, as well as differentiating from aneuritic lateral sclerosis and spastic paraplegia.

In closing the discussion Dr. Moore drew attention to the fact that the case of disseminated sclerosis had been diagnosed and treated as locomotor ataxia, and that in making differential diagnoses between tabes and other central nervous diseases, if it is always borne in mind that the symptoms of tabes are principally and primarily sensory there will be fewer mistakes made in this important class of diseases.

DR. GRANVILLE MACGOWAN:—Presented by invitation, a patient having a somewhat rare skin disease, due to one of the yeast fungi—the *Blastomyces*. On man's foot were several verrucous patches one eighth to one quarter inch above the skin, partially covered with crusts. Many milium abscesses extended into soft base and from these a mucopus exuded which contained the blastomyces, the fungus responsible for this blastomycosis of the skin. Original lesion in this man had been on the right shoulder and he had cured this with some cancer paste, while the other patches had been treated by one physician for months on the supposition that they were cancer.

The differential diagnosis between blastomycosis of the skin, skin cancer, tuberculosis of the skin, and syphilis was given. Dr. E. Leonard exhibited under the microscope a slide showing the fungus. The treatment of the condition was outlined, Dr. MacGowan having decided to use concentrated sunlight in this case.

DR. E. L. H. SWIRT presented a patient suffering from *Akromegaly* concerning whom he gave the following history: The patient I present to you is 30 years of age; a farmer. He says he has been growing larger for 10 years. Four years ago he wore a No. 10 shoe. Now he wears a No. 12. He has been

gaining about 12 pounds yearly. In October, when I first saw him, he weighed 240 pounds. Now weighs 250. There is no family history of akromegaly. He has no sexual disturbance lately, but some years ago had frequent nocturnal incontinence.

In March, 1905, he went out shooting blackbirds, and endeavoring to shoot left-handed, on closing his left eye noticed that the blackbird he was aiming at had disappeared. Upon opening the right eye he was surprised to find the bird still there. Thus he accidentally discovered some visual defect in left eye. I saw him in October, he seeking an oculist, because of continued failure of left eye, when an ophthalmoscopic examination revealed atrophy of the retrobulbar segment of the optic nerve, causing a central scotoma for white, as shown in the diagram, which I will pass around, obtained from the readings of the perimeter. There is no color perception with this eye. The pupils somewhat dilated, left more than right. They react to light and accommodation.

He complained off and on of severe neuralgic pains in frontal region and left temporal region. He had off and on violent neuralgic pains in left eye, so bad that he felt like tearing it out, as he described it. Right eye vision 20-30. No lens improves. There appears to have been a previous neuritis in this eye because the edges of the disc are obscure and a mild degree of incipient atrophy. The perimeter indicates a contraction of visual field. Vision left eye 2-200 in October. This is now decreased till unable to count figures. No abnormality to hearing. Sense of smell normal, also taste. No pains in joints or in other part of body. No paraesthesia. Has feeling of great apathy and heaviness and indifference. Feels tendency to go to sleep in day time, but since administration of strychnine this has disappeared. No loss of memory lately, but several months ago

felt that it was failing him, that as he expressed it, his brain was not acting properly.

You will notice the attitude. Head thrown forward. Chin slightly tilted forward. Back humped. Shoulders rounded. Arms, on account of cervico-dorsal kyphosis, apparently increased in length.

You will notice massiveness of features: Nose large. Chin projects. Cheek bones exceedingly high. Supra orbital ridges exceedingly prominent. Face as a whole of unusual length and breadth.

Nose is enlarged in all its parts. Size of lower jaw increased; it is broad and thick. Teeth of lower jaw are displaced, especially incisors, so that they protrude beyond upper teeth, but the spaces between the teeth are not increased. The body of the lower jaw is much more enlarged than the rami. Lips are enlarged and thickened, especially lower lip. Ears and eyelids are not enlarged. Upper jaw not much enlarged. Malar bones enlarged causing high cheek. Eyeballs neither prominent nor sunken. Tongue enlarged, not indented by teeth, but no especial awkwardness in speech. No hypertrophy of uvula, arches or tonsils. There is great thickness and unusual thickness of hands and fingers, joints of hands prominent. Skin, connective tissue and fat excessively thickened. On palmar surface, transverse lines much accentuated. Ulnar borders are more hypertrophied than other portions. There is a disparity between size of hands and their strength. His grip is not as strong as one would suppose. Fingers sausage shaped. Size of nails not in proportion to size of hands. They are flat and longitudinally striated or ridged. Size of forearms not in proportion to hands. Sternum and clavicle not enlarged. Scapulae prominent and large. Foot broad, toes thickened, especially big toe. Heel projects backward to excessive degree.

Outer edge of foot especially hypertrophied. Tendo achillis and malleoli not especially large. Arch of foot not lost. The patellae enlarged and hips broad. Leg and thigh normal in size. His gait is lumbering and heavy. Hips are prominent. He perspires profusely, especially lately since he has been on K. I. Receives strychnine 1-60 b. i. d. No increased thirst or appetite.

#### DISCUSSION OF DR. SWIFT'S PAPER.

DR. THOMAS R. McNAB:—Referred to two cases of the disease in which enlarged thyroid was present, both cases responding well to the thyroid extract. The connection between thyroid, pituitary and adrenal glands was very interesting.

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DR. H. G. BRAINERD:—Cited a case seen at the New York Academy of Medicine in which attending physician had reported diminution in size of feet and hands, from treatment with fresh pituitary glands obtained from the abattoir.

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Reports of cases were then called for:

DR. F. C. E. MATTISON:—Presented a bottle of 38 small gall stones of peculiar pearly white color. Saw the patient five years ago. Had recurrent attacks of cholecystitis. In one of such attacks, on February 8th, he had persuaded her to be operated upon, and on that occasion had removed these stones.

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DR. A. TYROLER:—A week ago a patient from Nevada had come to him with an ulcer of three weeks' standing, on the great toe. History and examination negative. Ulcer fails to respond to antiseptic treatment. Asked for suggestions.

DR. E. SWEET:—Had gotten good results from ichthol in similar cases.

DR. F. C. E. MATTISON:—Had seen enzymol, through its digestive action, bring good results in torpid X-ray burns.

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DR. L. D. JOHNSON:—A young woman of 30, previous health good, history negative, had a sudden eruption appear on the feet, itching, burning, painful. Large watery blisters appeared on sides of feet and on heels and toes. After 24 hours pain subsided. Feet looked almost gangrenous. Blisters later contained thick yellow fluid. Tissue beneath looked red like junco comb. After some weeks, skin began shriveled. Patient able to walk again. The cause cannot be placed and the course is very unusual.

DR. A. L. KELSEY:—Cited a case of complete adhesion of soft-palate to post-pharyngeal wall, due to syphilis, twenty years ago, and fifteen years ago a Seattle surgeon had endeavored to make openings by two lateral incisions and the use of rubber bands but had failed.

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DR. J. A. MCGARRY:—Reported a case of otitis media, with pronounced bulging of the drum, but in which whispering voice could be heard at 20 feet. Could not understand absence of deafness. Had subsequently punctured drum in posterior quadrant and blood and pus had exuded.

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DR. S. A. AUSTIN:—Reported case of pneumonia, woman, 50 years, with fever, increased respirations and heart action; claimed no chill; found dullness over right apex which extended. Consultant advised codeine for extreme restlessness. Another patient had chilliness but no chill. Pain as in previous case commenced in the head. Dullness over right apex. Sent patient to hospital. On third day rusty sputa appeared which changed four days later to orange yellow color.

DR. GEORGE L. COLE:—Felt that while morphine was valuable during first two days of a pneumonia its action at later periods was to be carefully watched.

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DR. F. C. E. MATTISON:—Patient with empyema. Had had a lobar pneumonia with pleurisy and was referred later to Dr. Mattison. Five quarts of pus were measured off and probably three more quarts escaped.

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DR. E. M. LAZARD:—Reported a case of acetanilid poisoning due to headache powders. Found patient blue and bordering on collapse.

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DR. GEORGE L. COLE:—A year and a half ago saw for a short period a young woman patient with severe mitral regurgitation, whom he expected to see die almost any time. Went on however to a very good recovery, but during the last few weeks had suffered a mild recurrence. Case was interesting in showing that prognosis is not always bad in this condition.

#### MEETING OF FEBRUARY 23.

This meeting was designated by the Council of the Association as the occasion for the organization of an Obstetrical Section of the Society. Dr. M. L. Moore had been invited to take charge of the meeting, the members present organizing by the election of Dr. M. L. Moore as chairman, Dr. J.



H. Seymour as Clerk and Dr. Titian Coffey as Councilor. The chairman appointed a committee of three, consisting of Doctors Paul A. Adams, Sherwin Gibbons and E. M. Lazard, to draw up a constitution and by-laws and to report on the same at the next meeting.

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In opening the meeting, Dr. M. L. Moore stated his gratification at the action of the Council in deeming Obstetrics, (a branch of medicine practiced by nearly all practitioners,) as being worthy of a separate section. He was sure the section could be made a source of much aid to its members. For himself he was by no means proud of the manner in which he had practiced obstetrics in the earlier years of his career, and if the members of the section would keep case histories, there was no reason why there should not be an abundance of interesting material to draw from, so that by the end of the year, every member would have material for an excellent paper.

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DR. E. M. LAZARD read the paper of the evening entitled "*Some of the More Unusual Causes of Disturbed Puerperium.*"

The term puerperal fever should give way to the term puerperal infection, since there were conditions other than infection which might give rise to fever in the puerperium. The term fever, among the laity was interpreted to mean infection, and the term on that account not infrequently was a source of undeserved reproach, even when all aseptic precautions had been successfully practiced.

There are oldstanding cases of latent bacterial infection which remain in abeyance during pregnancy, but which light up into activity after confinement.

Phlegmasia dolens is another condition not dependent on infection which may lead to fever. Other post-partal

fevers may be due to intestinal absorption, or typhoidal infection may complicate. Again the cause may be malaria. The case-histories and charts of several patients suffering from some of the conditions cited, were appended to the paper.

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#### DISCUSSION OF DR. LAZARD'S PAPER.

DR. M. L. MOORE:—Commended the contention made by the essayist and cited several experiences of his own in verification.

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DR. T. G. DAVIS:—Took issue with the essayist in giving Semmelweis rather than Oliver Wendell Holmes the credit for calling attention to causes of the classic puerperal fever or infection. Felt that too often practitioners are blamed for puerperal fevers not due to infection.

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DR. F. C. E. MATTISON:—Cited the case history of a patient with typhoid during the puerperium. Advocated the use of rubber gloves as one of the best of aseptic precautions.

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DR. ELIZABETH FOLLANSBEE:—An obstetrical case should have given to it the same attention as regards sepsis as is given to a surgical case.

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Dr. M. L. Moore then called for reports of cases, stating that no program had been prepared since the organization of the Section was the major business of the evening:

DR. P. C. PAHL:—Was recently pressed into service to deliver a woman, in whom labor was very rapid, and where after delivery no perineal tear was found, but in which there protruded a firm mass that prevented the cervix from being reached except along posterior boundary of the vagina. The attending physician arriving at that time, Dr. Pahl retired from the case, but had not been able to learn the exact nature of the protruded tissue.

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DR. LASHER:—Was called on several years ago to do a Caesarian section, and upon arrival at the patient's humble home in Sonora-town, found an occluded vagina, into which not even the

ment could be entered. Patient was in labor. Rectal examination demonstrated a tumor mass which Dr. Lasher did not think was the child's head. Conditions were not favorable to Caesarian section so decided to explore through the rectum and found a dermoid cyst, which was evacuated, forceps applied to child and delivery completed without accident. Two years later on consultation with Dr. Karl Knitz, saw the same woman, the dermoid cyst having refilled. This was later extirpated.

Dr. ABBOTT:—Recently delivered a woman and had a small three-quarter-inch perineal laceration. As patient was under anaesthetic, repaired tear with four superficial and four buried sutures. Husband inquired as to number of stitches and on being told expressed his opinion that the tear was a very large one. Moral was to tell the husband the size of the tear and not the number of stitches.

Dr. M. L. MOORE:—Recently had under his care a primipara who had been in excellent health. Was under observation for six months, but her last specimen of urine showed a trace of albumen. He called the next day and found puffed eyelids, headache and other symptoms of toxæmia. Had nurse come, prescribed calomel, salines and sweats. Next morning patient was vomiting, symptoms were worse and she was transferred to hospital, but in the trip, the membranes were ruptured. By evening labor had commenced and dilatation had advanced to size of a dollar. Would have done version had waters not escaped. Did a mechanical dilatation, but efforts of himself and assistant with axis-traction forceps made no impression. General condition was growing worse and did a craniotomy which was done with great difficulty. Here was a healthy woman with normal pelvis with queer complication at the end. Showed the necessity of watching patients carefully throughout pregnancy.

## BOOK REVIEWS.

**NASAL SINUS SURGERY WITH OPERATIONS ON NOSE AND THROAT.** By Benjamin Bourlank, M.D., Professor of Diseases of the Nose and Throat in the New York Post-graduate Medical School and Hospital. Illustrated with 68 full-page half-tone and colored plates, including nearly 100 figures. Royal octavo, 26 pages. Bound in extra cloth. Price, \$4.00, net. F. A. Davis Company, Publishers, 1913 Cherry street, Philadelphia, Pa.

The author has given us a most excellent practical treatise, the text being most beautifully helped out by the variety and number of the illustrations. The surgery of the accessory sinuses is briefly but concisely handled. However, some of the latest septal operations such as Frier's are not mentioned by name. And this is also true in regard to some recent intra-nasal instruments coming from Chicago. Can it be possible that

out Eastern friends think that nothing good can come out of the West?

**LECTURES ON AUTO-INTOXICATION IN DISEASE, or Self-Poisoning of the Individual.** By CH. Eismann, Professor of Pathology and Therapeutics, Member of the Academy of Medicine and Physician to the Hospitals, Paris. Translated, with a Preface and New Chapters added, by Thomas Oliver, M.A., M.D., F.R.C.P., Professor of Physiology, University of Durham, Physician to the Royal Infirmary, New Castle-Upon-Tyne. Formerly Examiner in Medicine, Royal College of Physicians, London. Second Revised Edition. Crown octavo, 26 pages. Extra Cloth. Price, £2, net. F. A. Davis Company, Publishers, 1914-16 Cherry street, Philadelphia.

For a book to have become a classic within fifteen years is a triumph, but that has been achieved by this present volume. The main positions taken by

the author, though at that time new and radical, have been in all important respects corroborated by the later developments of medical science. A few modifications have been called for, but these have been chiefly in matters of detail.

The service which Bouchard has rendered to practicing medicine can hardly be over estimated. The conception that our patients, both in health and disease, are continually poisoning themselves, and only saved from serious consequences by the neutralizing activity of certain organs of the body, is a key which unlocks many problems by the bedside. Particularly fruitful has it been in the case of the poisons formed in the process of digestion and their neutralization by the liver, and the later work of Murray on the thyroid, and Abel on the adrenal, have simply enlarged and emphasized the value of Bouchard's original views.

It would be well for us if we would recognize these views even more fully and constantly than we do. While the work of the editor, Dr. Oliver, has been in the main admirably done, there are one or two points which a little more thorough bringing up to date could have been desired. For instance, in speaking of the part played by micro-organisms in the mouth and alimentary canal, he refers to the seventeen species of microbes isolated from the saliva, when Miller described thirty-six, at least six or seven years ago. But these are mere spots on the sun.

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A MANUAL OF DISEASES OF INFANTS AND CHILDREN. By John Ruhrah, M.D., Clinic Professor of Diseases of Children, College of Physicians and Surgeons, Baltimore. 12mo volume of 404 pages, fully illustrated. Philadelphia and London: W. B. Saunders & Company, 1905. Flexible leather, \$2. net.

Dr. Ruhrah is to be congratulated upon the production of a manual that presents the subject of pediatrics in such a clear yet concise manner. He has outlined the therapeutics of infancy and childhood in a way that cannot fail to

make for this work a place of first importance in its field. He has given explicit instructions for dosage and prescribing, and a number of useful prescriptions are appended. Infant feeding is given in detail. All the illustrations are practical, and include three inserts. A very valuable feature consists in the many references to pediatric literature so selected as to be easily accessible by the student, enabling him to ascertain the sum of knowledge on any given disease. We give Dr. Ruhrah's work our unqualified recommendation in so far as it is possible for a manual of this size to cover the subject.

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NEW (7TH) EDITION, THOROUGHLY REVISED. A MANUAL OF THE PRACTICE OF MEDICINE. By A. A. Stevens, A.M., M.D., Professor of Pathology in the Woman's Medical College of Pennsylvania and Lecturer on Physical Diagnosis at the University of Pennsylvania. Seventh Edition, Revised; 12mo of 556 pages, illustrated. Philadelphia and London: W. B. Saunders & Company, 1905. Flexible Leather, \$2.50 net.

We know of no work on practice of the same size containing so much practical information concisely stated, as this handy little book by Dr. Stevens. The author's epigrammatic style is no doubt the result of his extensive experience in the lecture room, enabling him to group allied symptoms in such a manner that they can be easily retained in the mind of the student. By a judicious elimination of theories and redundant explanations he has brought within a small compass a complete outline of practice of inestimable value. Indeed, for the student, the practitioner, and the nurse as well, we know no better manual.

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PROGRESSIVE MEDICINE, VOL. IV, DECEMBER, 1905. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 367 pages, 41 engravings and 5 full-page colored plates. Per annum, in four cloth-bound volumes, \$9; in paper binding, \$6; carriage paid to any address. Lea



PROCTOR & CO., Publishers, Philadelphia and New York.

With this volume *Progressive Medicine* completes its seventh year of publication. The work has from its inception embodied an earnest effort to present a contemporary record of the best that is being thought and done in medicine, both from a scientific and practical standpoint.

The plan and execution of the work are very practical. No medical man has the time to read all the medical literature of the world in all languages, and this is a part of the service rendered by *Progressive Medicine*. Its authors not only read, but also sift out the good and helpful matter and discard the useless or doubtful. This, however, is only the beginning. These authors, all of whom are selected for peculiar ability and experience in their special fields, interweave this matter with their own knowledge and achievements, and each tells a connected, logical, interesting original narrative, giving reports of their cases and investigations and abundant bibliographical references for those readers who may wish to carry their study deeper.

Under "Diseases of the Liver," by J. Dutton Steel on page 101, Schmidt is quoted as saying, "That the old statement which is sometimes found in recent text-books, that intestinal putrefaction is increased when bile is absent, is entirely wrong. Bile has undoubtedly some properties and the ethereal sulphates are increased in the urine in jaundice, but more reliable methods of measuring the intestinal putrefaction and of estimating the intestinal bacteria (Strasburger) show that putrefactive changes in the stool are really less than normal when bile is absent. The reaction of such stools is always acid, but that is due to the fatty acids present and not to fermentation.

The reason for this lack of putrefaction is found in the large proportion of fat in the stools of jaundice. Fat does

not putrefy and thus the albumin in feces from cases of pancreatic insufficiency, and consequently foul stools are not a symptom of liver disease, but of insufficient albumen digestion, such as is present in pancreatic diseases. Consequently, jaundice does not lead to enteritis, as does disease of the pancreas, and bile may be absent for long periods of time without intestinal irritation."

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene, and other topics of interest to students and practitioners by leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U.S.A., with the collaboration of Wm. Osler, M.D., Baltimore; John H. Musser, M.D., Philadelphia; Jas. Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; Thos. M. Reisk, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kitz, M.D., Vienna, with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipzig, Brussels and Carlsbad. Vol. III, XV series.

This volume comes to us with such names as Sanger Brown, Daniel R. Brower, and Charles H. Knight of this country, W. G. Sym of Edinburgh and Tuffier of Paris.

McPhedran of Toronto has contributed an interesting clinic on Membranous Colitis. After showing two rather typical cases, and giving their history, he speaks of the treatment as follows: "In the treatment of mucous colitis, the neurotic state should be kept in mind, as well as the bile affection. In many cases a cure will follow an improvement in the mental state resulting from a change of scene, removal from depressing surroundings or the over-zealous attention of friends. Probably not a few of the milder cases recover under reverses by which they are compelled to assume responsibilities, even to the over-taxing of their energies. In



"Three teaspoonfuls of cod-liver oil will never be replaced by three teaspoonfuls of cream or other fat."—Dr. A. Jacobi, *Therapeutics of Infancy and Childhood*. 3d ed., p. 127.

AS an addendum to Dr. Jacobi's statement, it can be affirmed with equal positiveness that three teaspoonfuls of Hydroleine—the pancreatized Emulsion of Cod-liver Oil—will never be replaced by three teaspoonfuls of the ordinary, mechanically-formed emulsions. If you doubt this statement a trial will convince you of its truth. Write for sample and literature.

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well marked cases the Weir Mitchell rest cure, modified to suit the individual patient, especially with reference to the neurasthenic symptoms, give the best results. If the neurasthenia is only mild, complete rest in bed for a week or two may suffice, after which moderate exercise may be advised, according to the progress."

He then proceeds with the medicinal and dietetic treatment. He speaks of following Van Noorden's advice of a coarse vegetable diet with much butter and fat bacon. "The bowels are to be kept freely evacuated by sulphur at night and Homburg salts in the morning. He speaks also of the advantage to be gained by thorough massage of the abdomen to stimulate peristalsis and to displace fecal and mucus collections that might be lodged in the colon."

On page 198, Thomas D. Luke of Edinborough contributes a very interesting article on Ethyl Chloride as a general anesthetic. He says, "at the present moment the fact is generally becoming recognized in the United Kingdom that in ethyl chloride we have an exceedingly valuable anesthetic. The fact has been fairly well established that no admixture of ethyl bromide or methyl chloride is necessary or indeed desirable or advantageous. However, he records eight deaths due to ethyl chloride when given as a general anesthetic. He makes the statement, however, that Seidz has collected a series of cases numbering 17,000, with only one fatality, and Ware, working in a comparatively different area, arrives at almost the same result."

The *International Clinics* have become established as one of the most substantial works in the medical literature of the day, and it is very doubtful whether the same amount, and quality of material can be procured for anything near the modest sum of \$2 per volume.

**MINOR AND OPERATIVE SURGERY INCLUDING BANDAGING** By HARRY B. WHARTON, M.D., Professor of Clinical Surgery in the Woman's College, Surgeon in the Freeborn Hospital, Philadelphia, etc. New 1906 edition, enlarged and thoroughly revised. In one thick volume of 652 pages, with 224 illustrations. Cloth, 35 net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906.

Dr. Wharton's work has for many years been the accepted authority in its field, and justly so.

In its many revisions its scope has been gradually broadened in response to the suggestions of its many readers, so that in the present edition it really covers all except what might be termed capital surgery. Thus, there have been included many operations such as tracheotomy, intubation of the larynx, operations on the stomach, gall-bladder, kidney and intestines, and those for appendicitis and hernia, together with many others which are somewhat beyond the vague line which separates major from minor surgery. The increased attention which is given in the medical colleges to operative procedures on the cadaver and the importance of this method of instruction have led the author to include those operations which can be advantageously taught in this way, such as ligation of arteries, amputations, excision of joints, operations upon nerves and tendons, intestinal anastomosis, etc., etc. The various bandages and surgical dressings are clearly described, and illustrated by numerous engravings, many of which are photographic, and all of which are most helpful. Particularly will the helpfulness of the illustrations be shown in the section of bandaging where almost every variety of bandage or dressing is explained in detail, and shown

with such clearness that a novice could scarcely fail in the application of one.

The importance of sepsis and antisepsis has received full consideration, and surgical bacteriology is covered in a special chapter.

**NEW EDITION, REVISED. NERVOUS AND MENTAL DISEASES.** By ARTHUR CHURCH, M.D., Professor of Nervous and Mental Diseases and Medical Jurisprudence in Northwestern University Medical School, Chicago; and FREDERICK PETERSON, M.D., President of the State Commission in Lunacy, New York. Clinical Professor of Neurology and Psychiatry, Columbia University. Fifth edition, revised and enlarged. Octavo volume of 377 pages, with 39 illustrations. Philadelphia and London: W. B. Saunders & Company, 1906. Cloth, \$2 net; half morocco, 35 net.

It is not at all surprising to us that a fifth edition of Church & Peterson's work should be necessary. Indeed, such a success was to be expected from what is undoubtedly the most complete and authoritative volume on nervous and mental diseases today. In preparing this edition Dr. Church has carefully revised his entire section, placing it in accord with the most recent psychiatric advances. In Dr. Peterson's section—*Mental Diseases*—the Kraepelin classification of insanity has been added to the chapter on classifications for purposes of reference, and new chapters on manic-depressive insanity and on dementia precox included. While the changes throughout have been many, they have been so made as but slightly to increase the size of the work. A number of the illustrations have been replaced by newer and better ones.

On page 800 appears the following: "Manic-depressive insanity is best exemplified by cases of circular insanity, in which we have recurring cycles of maniacal and melancholic outbreaks. But it is a merit of Kraepelin to have studied large numbers of patients suffering from mania or melancholia for periods of years, delving deeply into their previous histories, and following them up long after they have left his immediate professional care. \* \* \*



"The term, manic-depressive insanity, is thus made to cover almost all of the old types in insanity that were formerly looked upon as sharply defined insane syndromes, viz., manic, melancholia, and circular insanity.

"Kraepelin naturally assumes for manic-depressive insanity an identical pathology for its contrasted or mixed manifestations, though what such pathology may be is wholly a matter of speculation.

"There is no doubt that we owe Kraepelin much for the new views thus given us. It may be, however, that modifications will be made as time goes on in this conception of the manic-depressive syndrome. The brilliant exponent of manic-depressive insanity has the advantage of us at present in having already accumulated his material requiring decades of observation for verification, while we must wait years yet with our own cases before determining for ourselves the ultimate truth of his conclusions."

On page 317, in Chapter 12, Peterson gives us the following: "Dementia Praecox is a disease beginning usually in the early life, and characterized chiefly by a more or less marked and peculiar enfeeblement of the mind, but manifesting upon this basis a considerable variety of

symptoms, such as weakness of judgment, flightiness, verbigeration, automatic obedience, catalepsy, echopraxis, stereotypy, negativism, mutism, impulsive actions, affectations, grimaces and unemotional laughter, delusions of a depressed or grandiose nature, and hallucinations.

"It is not easy to offer a brief and clear definition of dementia praecox, and I have made the above from an analysis on the Kraepelin descriptions of the multiform phases of this psychosis. He has brought together under this name a group of mental disorders, the distinguishing feature in all of which is the special type of dementia most clearly outlined in the terminal conditions.

"There are cases in which all of the physical functions are equally enfeebled, as in the disorder which we have been accustomed to call primary dementia, and which type is now included in the new category. These are exceptional. The characteristic of the enfeeblement of mind in dementia praecox is the irregularity of weakening of the several faculties, a sort of selective deterioration."

We can confidently say that this work will maintain the reputation already won.

## THERAPEUTICAL HINTS.

### BEST UTERINE TONIC AND ANTISPASMODIC.

Dioiburnia is the best tonic and antispasmodic, relieving the pains of dysmenorrhea and regulator of the uterine functions. I cheerfully give this recommendation of Dioiburnia. L. Ch. Boisligniere, M.D., late Professor of Obstetrics, St. Louis Medical College.

The *Journal of Practical Medicine* claims that tablets are far better than capsules, as they can be made absolutely accurate, and that the tablets dissolve more quickly than the capsules. Antikamnia tablets disintegrate at

once, as soon as they come in contact with moisture. Drop a tablet in a glass of water and be convinced.

Lewkowitsch says that cod-liver oil is more easily digested than other fats because it is more readily hydrolysed and oxidized, owing to the peculiar constitution of its unsaturated fatty acids. The digestion of cod-liver oil is greatly facilitated by effecting its emulsification by a process of partial hydrolysis, a process that has been successfully employed in the preparation of the hydrated cod-liver oil known as Hydroleine.

## MISCELLANEOUS.

## LIBRARY PASTE.

(1.)

(L. Z. L.)—Dissolve 2 drams of alum in a quart of water and add flour sufficient to make a thick cream. Powder together 10 cloves and a dram of resin and stir the powder into the cream. Put on the fire in a vessel of sufficient size 4 ounces of water and bring to a boil. When in active ebullition, pour into the vessel the mixture of flour, etc., in a thin stream, stirring all the time to prevent burning. Pour into an earthenware vessel, cover tightly and keep in a cool place. This paste keeps well, and replace cover on container. If needed, thin down with boiling water.

(2.)

Rice starch	2 ounces
Gelatin	6 drams
Water	16 fl. ounces
Oil of cloves	15 minims

Incorporate the starch powder with the water, add the gelatin and heat gently over a water bath until a jelly-like compound results.

(3.)

Best Bermuda arrow- root	1 $\frac{3}{4}$ ounces
Sheet gelatin or best Russian glue	80 grains
Water	15 ounces
Methylated spirit	1 ounce

Put the arrowroot into a small pan, add 1 ounce water and mix it thoroughly up with a spoon, or the ordinary mounting brush until it is like thick cream; then add 14 ounces water and the gelatin broken into fragments. Boil for four or five minutes, set aside until partially cold, then add the methylated spirit and six drops of carbolic acid. Be very particular to add the spirit in a gentle stream, stirring rapidly all the time. Keep the paste in a corked stock bottle and take out as much as may be required for the time and work it up nicely with the brush.

## RULES FOR THE BABY.

Baby is often sick because his mother is inexperienced and does not know how to care for him. Here are some simple rules that will be of service to any mother:

1. Nurse baby: Nothing equals mother's milk for a baby food. If you cannot nurse the baby, use fresh milk which in hot weather has been boiled and prepared according to directions. Nurse baby part of the time, if you cannot nurse it all the time.

2. Feed or nurse it at regular intervals, not more than once in three hours after it is six weeks old. Don't feed it simply because it cries. Decrease the amount of milk on very hot days. Too much food and too frequent feeding are among the commonest causes of sickness.

3. Bathe it daily: The glands of the skin carry off nearly as much poisonous matter as the bowels. They must be kept open in hot weather. Dry the skin well after bathing.

4. Air it: Out-of-door air is necessary. Keep the head shaded from the direct sunlight. In hot weather take the baby out early in the morning before nine o'clock, when it is cool, and again late in the afternoon and early evening, but not late at night.

5. Keep it cool: If it is bundled up too much in summer, it will become overheated. The more nearly naked it is, the better in extremely hot weather.

6. Keep it in a quiet place. A baby's nerves are very sensitive; continued noise sometimes causes sickness.

7. Give it water: Between feedings give water freely, especially in hot weather. Use only water that has been boiled.

8. Give no fruit to a baby less than a year old. In summer give no fruit to a baby less than two years old. Fruit kills many babies.—*The Healthy Home*

# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## INTESTINAL OBSTRUCTION IN CHILDREN.\*

IN THE SERVICE OF WILLIAM A. EDWARDS, M.D., LOS ANGELES, CAL., PROFESSOR OF  
PEDIATRICS, COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

REPORTED BY DR. EDWARD CLARENCE MOORE, ASSISTANT ATTENDING PHYSICIAN.

Gentlemen—Today we shall consider the general subject of obstruction of bowels in children, and if you will look at the blackboard and these animals, we shall study with you the probable

causes of Intestinal Obstruction, its diagnosis and its treatment.

The causes may be grouped as follows:

- (Partial Occlusion of the Anus.
- (Complete Occlusion of the Anus.
- CONGENITAL MALFORMATION ..... (Imperforate Anus.
- (Occlusion of Rectum.
- (Imperforate Rectum.
- (Abnormal communication between
- (bowel and vagina in female.
- CONGENITAL MALFORMATIONS WITH AB- (Between bowel and urethra or bladder
- NORMAL OPENINGS..... (in male.
- (Between bowel and surface of skin in
- (groin, or umbilical region.
- CONGENITAL OCCLUSION OF THE SMALL
- INTESTINE.
- FOREIGN BODIES, USUALLY SWALLOWED
- BY CHILDREN.
- ENTEROLITES, OR INTESTINAL CONCRE-
- TIONS.
- FECAL ACCUMULATION.
- VOLVULUS (RARE IN CHILDREN.)
- INTESTINAL PARALYSIS.

\*Being a synopsis of a series of lectures and demonstrations in the Pediatric Department of the College of Medicine of the University of Southern California.



## INTESTINAL STRANGULATIONS.

(Strangulated Meckel's diverticulum.  
(Adherent vermiform appendix.  
(Holes or holes in mesentery or omentum.

(Hernia, either the result of inflammatory changes in peritoneal surfaces, or from obliterated or patent omphalo-mesenteric vessels.

## HERNIA. (EXTERNAL)

(Inguinal or umbilical, either in children, may contain many of the abdominal or pelvic organs, as ovary, broad ligament, appendix, portions of the liver, testicle, etc.

(Femoral hernias are extremely rare in childhood.

(Diaphragmatic hernia—through the foramen of Morgagni.

(Hernia through foramen of Winslow—that is, from greater to lesser peritoneal cavity.

(Hernia recessus duodeno-jejunalis, or Trietz's hernia. Obturator hernia through the obturator foramen.

## HERNIA. (INTERNAL)

(Into the ileo colic fossa.

(Hernia (Into the ileo caecal fossa.

(in the (Into the sub-caecal fossa.

(paracæcal (Into the inter-sigmoid fossa.

(fossac. (Diaphragmatic Hernia—

( Through the Foramen

( of Morgagni.

(Ileo caecal. 50 per cent.

INTESTINAL OBSTRUCTION (THE MOST USUAL) (Ileo colic-caecal. 25 per cent.

Form of OBSTRUCTION IN CHILDREN.) (Enteric ileo caecal, 20 per cent.

(Colic. 4 per cent.

## PYLOTIC STENOSIS IN CHILDREN.

So, when you are called to see a child presenting the symptoms of intestinal obstruction, it will be necessary for you to have this scheme of possible causes clearly in your mind at all times; we shall therefore consider these described conditions seriatim:

CONGENITAL MALFORMATIONS.—The congenital defects which may cause intestinal obstruction may be classified as partial or complete occlusions of the terminal intestinal tract; as partial or complete occlusion of the anus; occlusion of the rectum; imperforate rectum,

and occlusion or imperforation, with abnormal openings, as stated above.

Partial Occlusion of the Anus.—If the occlusion of the anus is partial, a small opening exists, which while it permits an escape of a small portion of meconium, still is insufficient to allow the proper evacuation of the bowel. On this account, you may overlook the condition until the marked discomfort of the infant and the distention of the abdomen lead to a careful investigation, when you will find an opening which

will only permit the passage of a very small probe.

The treatment is that which we shall demonstrate to you now, and consists in the introduction of a blunt-pointed knife, cautiously making radiating incisions; dilatation must be maintained by the daily introduction of the finger, or a bougie, until the wound heals without contraction.

In complete occlusion of the anus, the obstruction is maintained by a more or less thick membrane, which becomes tense and bulging when the child cries or struggles. Often the color of the meconium may be recognized through the membrane. Here the symptoms are both more urgent and more marked.

In our service in the Philadelphia Hospital, it was the custom to make a crucial incision, cutting away the resulting flaps, and stitching together the skin and mucous membrane. This we shall now do before you in this dog, in which the obstructing membrane has been artificially produced. The use of the finger or bougie will also be required here for several days, to assure permanent dilatation.

*Occlusion of the Rectum.*—Presents an anus which seems to be normal. The occluding membrane is usually from 1 to 3 C.M. above the external opening, and like partial occlusion of the anus, it is apt to be overlooked until symptoms of intestinal obstruction arise, when examination shows a bulging diaphragm within the rectum. In this situation, the free incision is no longer safe, so we shall make a small opening in the diaphragm and stretch to the proper diameter with forceps. Here, the bougie will be required for many months.

*Imperforate Rectum*—Is well represented here in the dog, which condition we have also produced artificially, under full anesthesia, of course.

This condition is always grave, as the entire rectum is usually absent, as you will see here. The anus is apt to be

imperforate, also. Usually a dilated pouch represents the termination of the colon and is found opposite the promontory of the sacrum, as we show you. It may occupy the left iliac fossa, rarely the right, and usually has a long floating meso colon. The diagnosis of the condition is difficult, and is apt to be confounded with imperforate anus, but as both are treated surgically, the matter will clear up as we proceed.

In imperforate rectum, we must decide between a perineal incision similar to that in imperforate anus, and a colotomy. The latter is the best procedure, and the artificial anus is to be made preferably more anteriorly than the textbooks tell you; we like a point midway on Poupart's ligament, and about 4 C.M. above the center of that structure. Here the intestinal contents are more easily controlled, and the patient is more cleanly. As they grow older, they can take care of the opening without the assistance of an attendant. While the abdomen is open, the possibility of bringing the bowel down and stitching it to a newly formed anus, must be carefully considered. This, of course, is far preferable to an artificial anus in the anterior abdominal wall. This unfortunately, can rarely be done, and the children must be submitted to the first procedure. More rarely the sigmoid flexure and descending colon are absent, as well as the rectum. In these cases, the caecum should, of course, be reopened in the right groin, as explained by Huguier, some years ago.

Inguinal colotomy is always to be advised in a child—it is less fatal, particularly in congenital malformations, than the posterior operation. Should the child survive, attempts later may be made to restore the natural passage. Demarquay's and Byrd's ingenious plan may be tried, which consists of the introduction, through the artificial anus, of a leaden or elastic ball, to which a thread is attached and brought out at the perineum. This is gradually tight-

anal and a pouch is formed, which will serve later as the new rectum.

**CONGENITAL MALFORMATIONS WITH ABNORMAL OPENINGS.**—In many of the varieties of congenital malformation with abnormal openings, there may be a communication between the bowel and vagina, or urethra or bladder, and the external skin surface. In the vaginal opening, you may introduce a blunt dissector through the abnormal opening, and project its end toward the position of the anus. Then cut down on this point and stretch the skin and mucous membrane together. The vaginal opening is to be operated at another sitting by a plastic procedure.

If the abnormal opening is through the bladder or urethra, the best plan is to lay the parts freely open, as in recto-vesical lithotomy. If the skin opening is below the region of the normal anus, restore the natural passage and treat the case as one of fistula-in-ano. If, however, the skin opening is a great distance from the normal position of the anus, it is better to refuse operation, particularly if the opening is in the groin or near the umbilicus, which shows that a large portion of the bowel is absent. The best we can do, is to dilate the abnormal opening and prevent fecal accumulation.

**CONGENITAL OCCLUSION OF THE SMALL INTESTINE.**—A *Complete Occlusion* is always fatal, and we have no operative procedure for its alleviation.

A *Partial Occlusion*, while grave, is not entirely hopeless under modern surgical methods. It is compatible with some prolongation of life, and until the contracted portion of the bowel is suddenly closed by a mass of indigested food, plug of mucus, or other matters, the symptoms of obstruction do not become alarming; then at times, the indication is to resect the constricted gut, if the child is old enough and strong enough to stand operation.

**FOREIGN BODIES.**—Foreign bodies, which are very frequently swallowed by children, do not often produce intestinal obstruction. Children sometimes also introduce large foreign bodies into the rectum. In treating cases of foreign bodies in the intestinal tract, be careful to avoid purgation. If a soft mushy diet is given, most of the bodies will pass *per vias naturales*. If, however, the body is too large to pass, as a spoon, lead pencil, button hook, key and the like, symptoms of acute obstruction may arise. The Roentgen Ray will assist in locating the offending matter, and a laparotomy should be done at once.

As soon as the body is found, a small longitudinal incision is made in the gut, the body removed and the incision closed by a Cushing stitch of cat-gut, or fine silk. If the foreign body is in the rectum, it may usually be extracted by the careful use of forceps.

**ENTEROLITHS OR INTESTINAL CONCRETIONS.**—These are seen in children—they may consist in either vegetable substances from the food, *avenoliths* or oat stones, which Treves has shown to be frequent in Scotch children, or they may be made up of phosphatic salts, or cholestrin or amoniacal matter. Gall stones are almost never seen in children, and fecal accumulations are rare.

The treatment of these forms of obstruction is best met by non-operative measures; the administration of enemata are the safest—purgatives are too drastic. Opium and belladonna may be required to quiet intestinal spasm. Laparo-enterotomy is only indicated after all other measures have failed.

**VOLVULUS.**—This requires a relaxed and elongated mesentery, which is rarely seen in children, except in very rare congenital cases. Three forms have been described. The most usual is the twisting or folding of the bowel about an axis composed of mesentery or mesocolon. It may be twisted about



its own axis, or two separate portions of the bowel may be knotted together. The pain is severe and early it is paroxysmal; the tumefaction is irregular, but later the entire abdomen is distended, tender, with a continuous pain, usually referred to the umbilicus. Constipation is complete, and obstructive vomiting may, or may not, occur—certainly it is not a marked symptom.

The treatment is always operative, and after a laparotomy, the bowel is disentangled and re-sected, if necessary, and an attempt is made to prevent recurrence by shortening the mesentery, taking a reef in the relaxed and elongated membrane.

We still must consider the most important condition, which leads to intestinal obstruction in children—internal strangulation and intussusception.

INTESTINAL STRANGULATIONS. — Some of these are rare in children, others are frequent, and the strangulations, as you see by a glance at the schematic representation of the subject on the black-board, may be due to many different conditions, which we will consider separately:

*Meckel's diverticulum* is a sacculum of the ileum, owing to the non-obligation of the vitelline duct; as we see it clinically, it is a remnant of the vitelline duct passing from the lower end of the ileum to the umbilicus. This occasionally, although rarely in children, may become strangulated. The other conditions mentioned above are sufficiently explained by their titles.

In all of these, the most marked and accentuated symptom is pain—at first sudden, severe and continuous, without marked tenderness or pressure, until peritonitis develops. The pain then becomes colicky and is referred, in children, almost always to the umbilicus—vomiting arises early, is most distressing, and unless the case is operated and relieved, it soon becomes stercoraceous;

feces however, may not be vomited until about the fifth day, if you are unwise enough to defer operation until that time.

Constipation is absolute, collapse is imminent, and the temperature may be subnormal until peritonitis occurs.

The only treatment that offers the slightest hope is operation. Early recognition of the symptoms and early fearless operation may save the child. Immediately upon opening the abdomen, search rapidly for the cause of strangulation. Have in mind the above chart. Look for the most usual conditions first. If Meckel's diverticulum is strangulated, the mass will be near the lower end of the ileum and about the umbilical region.

*Adherent Appendix Vermiformis* may be found anywhere in the abdominal cavity. We have seen it transversely adherent, directly beneath the umbilicus in a girl aged eleven years; in a boy of fourteen it was found at the center of the left ileo—pectineal line, it may be in Douglas's pouch, or in an inguinal hernia; it may be in the right vertebral gutter, adherent to the tissues about the kidney, or to the under surface of the liver.

If the strangulation is due to *splits or holes in the mesentery, or omentum, or inflammatory bands, or constriction of the omphalo-mesenteric vessels*, it is usually recognized with great ease and readily relieved.

HERNIA.—The strangulation, as you have seen, may be due to external or internal hernia, the former, the EXTERNAL HERNIA, that is *inguinal, umbilical and femoral*, we have already fully considered, and demonstrated to you the various operations for their relief.

It is the INTERNAL, and more unusual hernia, which sometimes causes strangulation, that we wish to demonstrate today.

The peritoneal cavity has a number of apertures or fossae. Under the ordi-

nary conditions of development, these are entirely harmless. But, owing to anomalies of development, and other circumstances, they may become the site of intestinal strangulation.

*Hernia Through the Foramen of Winslow.*—The small intestine may enter the lesser peritoneal cavity or sac, through this opening. We have artificially produced this hernia for your inspection in this dog, and you will see that several loops of the ileum are herniated into the smaller sac.

If the diagnosis can be made during life, and the symptoms of strangulation here are the symptoms of strangulation elsewhere, the intestines should be reduced to their normal location and the enlarged opening in the foramen reduced in size, or even obliterated, a few catgut sutures may be introduced to do this, or probably the necessary handling will set up enough peritonitis to accomplish the same object.

*Hernia Recessus Duodeno-Jejunalis, or Trietz' Hernia.*—Where the duodenum becomes jejunum, a fold of peritoneum forms a semi-lunar opening to the left of the origin of the jejunum—it contains the inferior mesenteric vein. We show you the opening here; it is shallow, and not wider than your thumb.

Authorities have described several varieties of this recess. We will not confuse you with their description, as all that you require is the recognition of its existence; that it varies in outline, and that it is sometimes responsible for strangulation and obstruction of the bowels. When the intestine finds its way into this fossa, it enlarges the opening and forms a retro-peritoneal hernia. This hernial pouch may stretch to great size to the left, under the descending colon, and even downward to the pelvis. It may, on the other hand, find an upward direction under the root of the transverse meso colon, behind the stomach and spleen.

The small intestine is usually alone involved, but cases are recorded in which the sac contained not only the small intestine, but also the caecum, and a portion of the colon.

Again the small intestine, when herniated into the fossa, may present in front of the great omentum, the transverse colon and stomach, and the caecum and vermiform appendix appear above the lesser curvature of the stomach, as they passed behind the stomach and then forward through the gastro-hepatic omentum.

*Hernia in the Pericaecal Fossa.*—may be one of four varieties, as you see by the chart. Three of these fossae are found near the ileo caecal junction, and any of them may be the site of an internal hernia and gut strangulation, if the usual relations have been changed by appendicular involvement.

The ileo colic fossa lies above the ileum, and below the ileo colic fold, which contains the colic branch of the ileo colic artery. The ileo caecal fossa is below the junction of the ileum, with the caecum. This may be a very large fossa, and extend upward behind the ascending colon, even as far as the right kidney. The subcaecal fossa lies beneath the caecum, and external to the meso appendix and meso caecum.

A fossa, variable in size—the *inter sigmoid fossa*—is found in the lower left surface of the meso sigmoid.

*Diaphragmatic Hernia.*—While the diaphragm has several openings, the principal one is that between the costal and sternal regions of the muscle, and is the foramen of Morgagni. Hernia through this foramen is provided with a double sac, one of the pleura and one of the peritoneum, and is called a peri-sternal hernia.

Very few of these hernia are recognized during life, but a number are seen on the autopsy table, or at operation. They commonly arise from trauma, either from knife or bullet wounds, but

when an operation is done for an obscure abdominal strangulation, the possibility of this hernia existing must not be overlooked.

*Obturator Hernia* occurs through the obturator foramen between the horizontal ramus of the pubis, and upper portion of the obturator externus muscle. The protrusion will be found to the outer side of the adductor longus muscle, and beneath the pectineus muscle, on the inner side of the hip joint capsule, and behind and to the inner side of the femoral vessels.

The hernia may be exposed by an incision over its most prominent point; after the skin, superficial and deep fascia, is divided, the pectineus muscle will be exposed, and at its inner border, in the interval between it and the adductor longus, the sac will be seen. Great care must be taken to avoid wounding the long saphenous and common femoral veins.

**INTUSSUSCEPTION.**—Intussusception is the most common form of intestinal obstruction occurring in children. As you see here, it consists of the introduction of one portion of the bowel into an adjoining portion. The lower portion or sheath is almost always below or nearer the anus than the portion which enters it. The jejunum becomes invaginated into the ileum, the ileum into the caecum, and the colon into the rectum.

These forms are sometimes called the direct intussusception. If you will look at this complete intussusception, which has been artificially produced in this animal, you will see that it contains three layers, each embracing all the coats of the bowel. If we start from the inside out, the innermost layer is called the entering layer, the next one the middle or returning layer, which constitutes the invaginated part, or the intussusceptum; the third, or outermost layer, is called the sheath, receiving layer or intussusciens. Where the en-

tering and returning layers join, that is, the lowest point of the intussusception, it is called the *apex*, while the returning and receiving layers, the highest point of the intussusciens, is called the *neck* of the intussusception. We will reduce the intussusception, and as one layer recedes from another, it will be made very clear to you.

The next mass that you see higher up the gut, is an artificially produced *double* intussusception, involving four layers of gut. It may be produced by either driving a second intussusception into the first, which then forms its sheath. Again the first intussusciens with its contained intussusceptum, may itself be invaginated in a fresh part of the bowel, this constitutes a second sheath. Triple intussusception, containing *seven* layers of bowel, may be met with. We have produced this intussusception in the neighborhood of the ileo caecal valve, because more than one-half the intussusceptions occur in that region.

The usual course is for the caecum to become inverted, followed by the small into the larger intestines. The invagination then increases at the expense of the small intestine, the neck constantly changing position, while the apex remains constant, formed as it is by the ileo caecal valve, which in children may ultimately protrude through the anus.

This ileo caecal form is more common than the ileo colic, in which the small gut slips through the valve, which constitutes the neck of the intussusception.

Intussusception involving alone the small intestine constitutes less than one-third of all cases recorded. These ileal and jejunal intussusceptions are therefore rare, but not as rare as those limited to the large bowel. These colic intussusceptions are only one-sixth of the whole.

You must remember that all invaginations, except the ileo colic, increase at the expense of the intussusciens. This



causes a change of position of the tumor. The most common form, the ileo caecal, while it originates on the right side, usually reaches the middle line on the left side of the abdomen before we recognize it by external palpation. This variety in children can almost always be felt by digital examination of the rectum. Notice that the entering layer of an intussusception always carries the mesentery with it. Traction is thus exerted on one side of the intussusception, the apex is displaced, the bowel curved or bent, sometimes very sharply on itself; thus the degree of obstruction is increased, and perhaps a sudden aggravation of the symptoms produced by partial or complete strangulation of the gut. From several inches to several feet of bowel may be included in an intussusception; indeed, the apex of an ileo colic intussusception may protrude at the child's anus.

Etiology.—The etiology of intussusception is still in the domain of controversy. Nothnagel is probably right in describing two varieties, a spasmodic and a paralytic. For a long time it was thought that the intussusceptum was pushed into the sheath or intussusciens by peristaltic action, but Nothnagel is inclined to think that the normal gut is drawn over the spasmodically contracted portion.

Treves holds similar views, and gives prominence to the longitudinal muscular fibres acting from the contracted segment, as a fixed point and pulling the uncontracted portion over the spasmodic gut. As a matter of fact, the cause of spontaneous intussusception is unknown. It has been demonstrated that at birth the width of the large intestine is only a few millimeters greater than that of the small intestine, and that before birth its diameter is the same, or even a little less.

At fifteen years it is two and a half to three times as large. The ileum does not double its diameter on the

course of growth, but the large gut of ten doubles its size, and may treble and quadruple it.

These are important facts when considering intussusception in young children. During the early months of a child's life, there is a rapidly increasing disproportion between the transverse diameter of the large and small bowel. An undo growth of the large intestine may allow the terminal portion of the ileum to prolapse into the colon. This may be the starting point of an intussusception, and the anatomical peculiarities of the individual will determine the pathology of the case; that is, whether or not the gut will become incarcerated and retained long enough to set on foot changes in the walls of the gut, or whether it will resume its normal relations. If the intussusception occurs in the region of the various fossae, detailed above, in which the lymphatic glands are numerous, with decided prolongations of the mesentery along the gut wall, the amount of tissue invaginated will render the intussusciens very tight; early adhesions will form, and the intussusception is almost at once irreducible. This is not so apt to be the case in the ileo caecal forms, as the colon has few and simple ileo colic folds, is comparatively devoid of lymphatic glands, and there is a possibility of spontaneous reduction, or it may run a chronic course without marked symptoms.

It is probable that the apex or head of the invagination, after it becomes firmly fixed, acts as a foreign body and causes further spastic contractions of the bowel; this carries the apex further downward, just as the other bowel contents would be expelled. While the anatomy of the child's bowel is an important matter, still it seems necessary to introduce some other factor in order to determine an intussusception. This factor in children seems to be an intestinal disturbance. Lichtenstem con-

siders this of paramount importance. In many cases, however, no exciting cause can be found; thus Fitz was unable to find such a cause in 42 cases. One-third of Hirschsprung's cases were absolutely healthy up to the time of onset, but the majority suffered from some intestinal disorder.

Age is an important factor—most cases will occur during the first year of life. Sixty per cent. of Hess's were under one year. In Gibson's series, 81 were under one year and 49 from one to 10 years. The greater liability of children is no doubt due to the relative length of the infantile colon, and the width of the meso colon, which probably favors the displacement.

As you will see here, the adjacent serous surfaces of the entering and returning layers of gut very soon become adherent; these adhesions extend over much space, and are densest in the region of the neck. In some chronic cases, the adhesions may be extraordinarily scanty, or almost absent. In acute cases, however, the intussusception quickly becomes strangulated, and if the adhesions are firm, it may slough off and pass per rectum, as a gangrenous mass, either intact or in fragments. The little patient may make a temporary recovery. If the adhesions are not firmly organized, fecal leakage may occur and fatal peritonitis may arise; again, the adhesions may be sufficiently organized to prevent leakage, but they will gradually contract and form a stricture, which may lead to fatal intestinal obstruction later.

When the children who die of intussusception come to the autopsy table, the picture is usually most characteristic. The elongated tumor formed by the invaginated gut, is readily recognized, and usually on the left side of the abdomen, a portion of the bowel seems to have disappeared—it is invaginated. The sheath will be grey, doughy and often ulcerated; the intussusciens is

of deep red color, or gangrenous black and pulpy.

Remember that the bowel below the seat of constriction or obstruction is almost collapsed and contracted, and contains blood and mucus. The gut above may be greatly distended with gas and fecal matter. General peritonitis may be present or absent.

Symptoms.—The symptoms of intussusception will be of great interest to you, as in these little children we must base our diagnosis entirely on what we ourselves can learn; they cannot aid us. Perhaps the two most striking symptoms of this condition are pain and suddenness of onset. This pain may attack an apparently healthy child, or one in whom there has been a few days or weeks of slight gastric or intestinal disturbances, while it is at play, at rest, asleep, or feeding, but the pain is always violent, sudden, intense, colicky or paroxysmal. Children refer this pain to the umbilicus, the legs are drawn up and the agony endured is plainly visible in the facial expression.

Vomiting, and a liquid fecal evacuation of the contents of the bowel below the seat of the disease, are two early symptoms. The temperature now rises, rectal tenesmus and the frequent discharges of a bloody mucus, with the presence of a tumor, usually on the left side, with a corresponding depression or flattening on the right iliac fossa, completes the picture of the typical intussusception in a child.

The future course of the case will now depend, in a large measure, upon the degree of strangulation of the intestinal and mesenteric circulation and of the intestinal lumen.

The train of symptoms which are notable and characteristic reach their maximum intensity in a very short time. The pain which early was paroxysmal, becomes continuous, with paroxysmal exacerbations, sudden cessation of this pain a little later is of evil prognostic

omen, and usually signifies gangrene of the gut, which will speedily be followed by perforation and death; sometimes, however, the separated slough may be discharged per rectum, and recovery result. Do not expect this.

Symptoms of marked prostration or collapse arise early, and are persistent; the pulse is small and rapid, vomiting recurs and may become fecal, and the passage of fecal matter does not now occur, by the usual route. Contrary to what you would expect, tympany or meteorism does not occur in the majority of cases—indeed, there is often a flattened almost scaphoid belly. This condition known as Dance's sign, is seen on the right side and is due to displacement of the affected bowel. In exceptional cases, you may recognize the tumor by an elevation of the belly wall. The presence of a tumor is most important. In 197 cases, with a complete history, collected by Hess, 183 presented an abdominal tumor—in 35 cases, a rectal tumor was present. In some, the abdominal tumor will be absent, but its presence in the rectum may be noted. The tumor may exist and be too small to be recognized by palpation; this often is the case in enteric intussusception. The site of the tumor is variable, and it is usually very movable in the acute cases. The chronic cases become adherent and immovable.

Differential Diagnosis.—In the differential diagnosis, you must have in mind all the conditions depicted in the chart on the blackboard, but many of these are so unusual that you can practically disregard them. Invagination, if mistaken at all, will be confounded with colic, appendicitis, enteritis, dysentery, impacted feces, opium poisoning, undescended and inflamed testicle, thrombosis of the mesenteric artery.

If a previously healthy child, or one who has had a little intestinal disturbance, gives you the symptoms detailed above, sudden abdominal pain, bloody

mucous stools, fever, and prostration, think of an intussusception first, and discard the other conditions by a process of exclusion. If vomiting, tenesmus, and absence of fecal evacuation are added to the picture, it is complete in every detail, and if palpation reveals a rectal or abdominal tumor, the diagnosis is absolute.

Prognosis.—The prognosis is always grave. Most cases in children are acute, and the prognosis is grave mainly on account of delay in diagnosis, and the application of the proper treatment. Early application of improved and modern surgical technique will reduce the mortality very, very much. This may be shown conclusively in a few words, by the statistics of Hess, thus: In 110 cases, in which laparotomy was done after efforts in reduction by irrigation had been made, 83 recovered and 30 died—a mortality of 30 per cent. In 74 cases in which laparotomy was the primary procedure, 69 recovered and 5 died—a mortality of 8 per cent. In the cases not operated (and there is always a doubt in diagnosis here), 34 recovered and 30 died—a mortality of 43 per cent. Whereas, with early operation, and here there is no doubt in diagnosis because it was verified, at operation, there was a mortality of 8 per cent.

We now come to a most important part of our subject—the treatment.

Treatment.—The older classification is most unfortunate, it was: first incarcerated, and, second, the strangulated forms of intussusception. If we had made our diagnosis and applied the appropriate treatment, the former would never become the latter. Such a classification is responsible for a majority of irreducible cases. In this service, the attempt to reduce an intussusception, is not only not advised, but most strongly condemned.

It is true that there is an inherent tendency to a spontaneous reduction in every intussusception, this period is a



short one, and only exists before paralysis of the muscular coat and the formation of adhesion renders it impossible. Children are practically never brought to us at this time. It is before pathogenic changes have taken place in the intestinal wall, that we can hope for any good from irrigation, or other mechanical means, and I repeat, we do not see these children until this stage is past. Furthermore, irrigations are dangerous for two reasons—first, they offer false hope and delay the proper surgical procedures, and secondly, Mortimer has shown that if sufficient pressure is used in children to accomplish the desired purpose, there is apt to be a cracking of the serous coat of the intestine. Other observers concur in this statement. If you try irrigations in your earlier practice, have a competent surgeon within call, prepared to open the belly at a moment's notice—you will need him; another strong argument against this treatment, is that the reduction may only be apparent and not real. Incomplete reductions are, in fact, the rule, a further indication for immediate surgical measures.

The treatment then that we would advise you to pursue is as follows: After you are sure of your diagnosis, at once prepare to operate. First, minimize shock, and place your patient, as you see us do, on a hot water bed, protect the baby's extremities well. Give as little anesthesia as possible, and have it given by one who is a pastmaster in the art.

Operate with the least possible delay, but always be cautious, expose and manipulate the viscera as little as possible. Make incision as small as possible, and protect the viscera with hot packs. We prefer the medium incision, as you see here; others like the rectus incision. The method of reduction is of prime importance, do as you see us, and apply pressure to the apex of the mass; never yield to the temptation to pull on the entering or proximal end, you may tear the bowel coats, one or

all. You may break slight adhesions thus—apply a blunt dissector between the layers, and gently break up the adhesions, as you see us do. If the reduction is difficult, or you are not satisfied as to the condition of the gut, bring it outside the peritoneal cavity and complete your manipulations extra peritoneal; tears and rents in the serosa are at once repaired by gut stitches, and are covered by omentum, if need be, to prevent leakage.

If it is difficult to re-introduce the inflated bowel into the peritoneal cavity, do not waste time and run the risk of further injuring the bowel, but at once enlarge the incision. Especially is this true in very young infants. It is sometimes necessary to puncture the bowel to gain time. Be careful not to include the distended bowel in the final closure of the abdominal incision. If the bowel has lost its natural gloss, you must not hastily conclude that it is moribund, but rather pick it up, and after gently stroking it until the vessels are empty, see if they readily refill, or after stroking, you may very gently nick the mesentery and see if it bleeds. If either of these things happen, the bowel is still viable.

The irreducible cases and these in which the gut is no longer viable, are of extreme gravity in these young infants. As early as 1899, several methods were suggested to meet these conditions: First, remove or excise the whole invagination, with end to end suture, or other union. Second, remove or excise the whole invagination and establish an artificial anus. Third, leave the invagination, and establish an artificial anus above it. Fourth, short circuit the bowel and let the invagination remain intact. Fifth, suture the entire piece of intestine to the intussusciens at the neck by continuous suture, then open the insheathing tube below the neck and extract the intussusceptum, and excise it within the sheath, or, if accessible through the rectum. Of these methods, we recommend the first,

which, up to the present time is ideal, and we will do it for you and make an end to end anastomosis by the Cannel suture, which we recommend to you above all others (operation done on an artificially intussuscepted dog). Before finally closing the abdomen, be sure that there are no other intussusceptions or other pathologic conditions which may

result in another destruction or a recurrence of the present one.

While it is true that the very young do not stand severe abdominal operations as well as the very old, still they stand them sufficiently well, as you have seen, to warrant us in undertaking the life-saving procedures.

## HYDROTHERAPY.

WALTER'S INTERVIEW ON THE SUBJECT WITH DR. SIMON BARUCH.

BY JULES KAHANE, ANGLES, LOS ANGELES, CAL.

While in San Francisco recently, on my way home from a trip in the northern part of the State, I heard, through a mutual friend, of the work of Dr. Simon Baruch of New York along the line of hydrotherapy, and learned also for the first time the history of the Riverside Public Baths of New York city. Perhaps because I have lived so many years in arid sections of the Southwest, and know so well the cost of water as well as of soap, and perhaps more especially because "a little knowledge is a dangerous thing"—especially to one's peace of mind—I determined, when I learned that Dr. Baruch had been largely responsible for introducing the Public Rain or Shower Bath to this country, to inform myself as far as possible regarding his work, and his theories of hydriatics.

I read with interest his address made to the physicians and surgeons of the San Francisco County Medical Society, and I later had the good fortune to spend some days at Paso Robles, where Dr. Baruch, his charming wife and little grandchildren were also sojourning. It was indeed a privilege to hear from his own lips the history of thirty years of active life in New York as a regular practitioner, of the gradual growth of

public opinion and the establishment of Public Baths in the city and throughout the state of New York, while the extension of the movement to other cities was indeed a story worth learning, even to the ears of one who is only a "newspaper friend" of the medical fraternity.

Sitting out at Suto's Baths in San Francisco, and gazing with mingled amusement and horror at the mass of black suited men and boys of all ages and degrees of social standing who mingle with a promiscuity that is absolutely revolting to one who has absorbed only the beginnings of the theories regarding microbes, and the transmission of unmentionable diseases in these swimming pools, it was then that I wondered why we in beautiful, progressive Los Angeles have no Public Rain or Shower Baths, and I determined that I would try to meet Dr. Baruch, and learn more of this matter.

The trip to Paso Robles on the Coast Line of the Southern Pacific is delightful at this season, and now that the new block system of electric signal has been installed, the last fear of travel has been removed for me, and I enjoyed much the fine hotel, the magnificent baths, and the experimenting with the (to me) new "Tonic Bath," likewise the inspection of the wonderful re-

sources of San Luis Obispo county at Santa Ysabel and other points, in the way of mineral springs and mud baths.

It was not difficult for me to interview Dr. Baruch on the subject of public baths, for he himself declared it to be his hobby, but when I approached him as to his practice concerning general hydrotherapeutics and the adoption of a systematic treatment with water for certain diseases, then I saw the silver crowned head go up in the air, the pleasant smile change to a severely cold and scrutinizing glance, and only the use of the name of the Dean of the Medical Department of the University of Southern California and the statement that I was a regular reader of the SOUTHERN CALIFORNIA PRACTITIONER bought me grace. I had to promise, too, on my honor as a newspaper woman, that my interview should be only for a medical journal, and not for a newspaper, because he said "the average newspaper reader immediately undertakes to apply his easily absorbed and undigested mental food, and often with disastrous results." And so—I promised, and now hoping that you will remember that all misuse of medical terms is due to my unfamiliarity with them and asking your forbearance, if I seem to have taken up, with a layman's enthusiasm, those things which most interest a layman, I will proceed to give you a brief resumé of what I heard from Dr. Baruch.

Quoting from an interview with John D. Rockefeller, which I had read in an eastern publication, I said: "It is wonderful what a powerful remedy water is!" Dr. Baruch laughed. I had just come out of the "tonic bath," where I had first gone into the "hot-box" or cabinet, for a good heating, then I had danced about gasping for mercy, while it seemed as if forty thousand little imps were teasing my skin with the needle-like streams of water at a temperature

which was altogether agreeable to the sensations; then I had had the hose turned upon my spinal column by a clever Irish girl, who showed her training in the way she humored me, and at the same time had her own way.

After a quick friction bath for fifteen minutes, I had been turned out fresh and new as a sixteen-year-old, and so I had come to Dr. Baruch for the promised talk.

Said the doctor, "There is nothing novel, startling or occult in hydrotherapy. Far from it, for I was led to its investigation by studies in medical history which I happened to make some thirty years ago. My youthful and impressionable mind was startled by the discovery that among the most renowned physicians were many followers of the Hippocratic *vis medicatrix nature* doctrine and that this therapeutic doctrine included reliance upon water as a remedial agent.

"After years of research and practice I pointed out, when appointed ten years ago to contribute to a symposium on 'The Stability of Remedial Agents,' that history shows that of all the remedies used in the days of Hippocrates only two have continued in practice, viz., regimen and water.

"My propaganda has been directed to the furtherance of a methodical, precise and judicious application of water in disease. Water is simple enough. Every physician is more or less familiar with its uses in disease but its methodical application has not been insisted upon sufficiently nor has its rational technic been taught with any degree of precision or earnestness.

"The medical profession had long been familiar with the application of rest and feeding in disease, but not until Weir Mitchell taught the methodical, precise application of these simple agents in the rest-cure did suffering humanity realize its enormous value in



many hitherto intractable cases. The many sins of omission and commission charged to the execution of Wey Mitchell's test cure and the many clumsy modifications made in its name, the author of this clearly devised system has often deplored.

"To remove slipshod, irrational application which has so long obstructed the universal adoption of water in disease has been a constant study and labor of my leisure hours for the last twenty years. It has proved a herculean task, but still it has become a labor of love and here at Paso Robles, with its perfect—certainly the most complete equipment for hydrotherapy of which I am cognizant in any part of the world, I am experiencing a real thrill of joy. It has been gratifying, too, to find that Dr. Stocking of the Agnew State Hospital is planning the installation of a complete therapeutic plant, and that the Medical Society of San Francisco is seriously considering the introduction of instruction in hydriatics to the training schools for both physicians and nurses.

"A deplorable neglect of this valuable therapeutic agent lies first in the lack of definite instruction in the medical schools, in most of which a superficial and sometimes an entirely incorrect idea of its application in chronic as well as in acute diseases, exists.

"As a result of this neglect the most astounding errors are committed in the technic and method prescribed, errors which result in failure and disappointment.

"And then the lack of precise knowledge of the clinical effect of water has resulted in its relegation to nurses, masseurs, and other empirics who have utilized it for mercenary purposes and are thus enabled to displace the educated physician.

"It is claimed that the medical curriculum is over-crowded. I should answer that a little judicious pruning of

the course in *Materia Medica* would leave ample time and opportunity for instruction on this neglected and valuable agent. To illustrate, in one of the recent and most concise text books, four pages are devoted to Antimony, despite the fact that the author has correctly stated that 'indications are not so generally recognized as formerly.' Arsenic received five pages, Asafetida one page, Bromide of Potassium five pages, Calcium three pages, Camphor three, Capsicum two, Chimaphila, Chirata, Cimicifuga, Haematoxylon and other inert medicines occupy valuable space in this excellent epitome of *Materia Medica*, while to the application of water in chronic diseases, one page containing an excellent illustration of the drip sheet is given, but the description thereof is faulty and refers only to the treatment of a symptom, insomnia.

"We must revert to basic principles to remove the prevailing opinion that because this agent is the chief resource of the empirics styling themselves hydropaths, it is unworthy of serious study and application in rational practice.

"No remedial agent is entitled to confidence unless its action has a rational basis, unless it may be administered in proper doses and its clinical results are convincing. All these conditions are fulfilled by water.

"It is perfectly feasible to subject water to exact and varied 'dosage' by increasing or diminishing temperature, duration, and pressure, and also by changes in the mode of procedure. Among the latter may be mentioned the ablution, affusion, drip sheet, wet pack, hip bath, full bath and plunge as well as the douche, which demands the facilities of an institution and is very effective in otherwise intractable cases.

"The skin is an organ permeated by nerves and blood vessels at every point. The cutaneous nerves and vessels are but the outlying portions of the life-controlling nervous and circulatory sys-

tem. The positive affects upon the whole organism may be elicited by the mechanical and thermic excitation of the skin.

"That the effects of the external and chief application of water in chronic disorders depend upon the irritant effect upon the cutaneous nerves and vessels is clear enough, but the method to be adopted in each concrete example must be learned from observation as is the case with other remedies, including medicinal agents, the administration of which is so simple that it is the favorite resource.

"It is so easy to write a prescription for iodide of potash, of colchicum, or aspirin, or colchescal or other new-fangled remedy for gout or rheumatism; to prescribe Glyco-phosphates, phosphagon, or some other new and often unpronounceable nerve up-builder in neurasthenia, which the polite agents and sample distributors of the new school of drug manufacturers offer, so that medical human nature but too often succumbs to the allurements, preferring such remedies rather than to reason out the more complicated but well tried physiologic remedies.

"The slipshod therapy of chronic diseases must be abandoned and in the application of no remedy does this apply with more force than in the use of water.

"It does not suffice to direct a patient to take a warm bath or a cold sponge or a turkish bath, leaving his whims and fancies and preconceived notions of the danger of shock and taking cold to modify the treatment. Full and explicit directions must be given as to the time, the temperature, the duration of the bath, and the conduct before and after it.

"As an illustration let me refer to the hydiatic management of an anaemic neurasthenic. When water treatment is prescribed at all it is limited only too often to advising cold sponging or the cold plunge. To obtain the tonic effect

of sponging, it must be followed by reaction and this may be obtained only by correct adaptation of the method to each individual. It is always a safe rule to order the treatment immediately after rising from bed because the cutaneous nerves and vessels are better prepared by the warmth of the bed to respond to the attack of the cold water. The bath room should be of not less temperature than 70 degrees and every precaution should be taken not to chill the body. To accomplish the latter more effectively, the patient should be directed to stand in a bath tub containing twelve inches of water at 110 degrees Fahrenheit.

"Into a basin of water at 90 degrees, which has been prepared in advance, a coarse wash rag or small towel is dipped which during removal is squeezed and then rapidly passed over successive portions of the body. The cloth is dipped and the superfluous water squeezed out of it and is repeatedly applied to various parts of the trunk with friction; the extremities are omitted, because they are easily chilled. After the entire trunk has been gone over, the patient should step upon a previously prepared bath towel or warm rug and be dried with friction. Each day the temperature in the basin may be reduced five degrees or less, always guided by the reaction resulting from the previous treatment. If the reaction be feeble or if the patient feels chilly or looks cyanotic the wash cloth should be more thoroughly wrung out, and only a portion of the trunk treated each time until reaction improves. This course should be pursued until the water temperature is reduced to 60 degrees Fahrenheit. Now the affusion is substituted and given every day. The procedure is administered by pouring upon the patient, who is standing in several inches of water of 110 degrees Fahrenheit. Dippers or basins full of water at 90 degrees are poured over successive portions of the trunk, beginning with the

back and shoulders and ending with the chest and abdomen. The patient is now dried and rubbed as previously described.

"Daily the temperature of the water in the basin is reduced five degrees until he receives affusions of 60 degrees Fahrenheit.

"It is an unalterable rule in hydrotherapy that water below the skin temperature, which is about 98 degrees Fahrenheit, should never be applied without friction, in order to prevent chilling, and to promote good reaction.

"In the ablation friction is made with the cloth; in the affusion the friction is made by the downpour of the water from the dipper or basin. The next step in home treatment is the daily plunge upon rising from bed, to which the skin usually responds well after the previous training just described.

"The plunge should also be taken in a warm room, the patient standing on a towel and stooping over the tub and lav- ing his face and hands with water dipped from the latter. The tub is two thirds full of water at a temperature of 60 degrees.

"The patient submerges his entire body and immediately steps upon a towel and dries himself.

"To illustrate a faulty plunge bath I may mention a case of a neurasthenic physician of great intelligence, who had been forced, because it depressed him, to relinquish the cold plunge which he had been convinced would invigorate him. On inquiring for a detailed recital of his method, I discovered that he remained in the water, the temperature of which he did not know, for several minutes, and dried his body without stepping out of the tub. The result was the chilling of the feet and absence of reaction, a fault which would have been avoided had he adopted the method just described. This home treatment requires no nurse. Any fairly intelligent per-

son may administer it successfully, if the physician gives precise directions.

"What is the rationale of this apparently simple hydiatic procedure? You perceive that it is merely the adaptation of the principle of peripheral excitation of the nerve and vessels terminals to the reactive capacity of the individual. If as is usually done, a cold sponge bath is ordered without the directions (seemingly needless) for temperature and method as here described, the water temperature might be 60 degrees in winter and 70 degrees in summer and it is likely that the attendant or patient would not execute the prescription conscientiously. For such is human nature. The temperature would be surely raised to satisfy the patient, the result would be simply a cleansing bath without reaction and therefore without the therapeutic effect. But after a series of systematic procedures, each producing reaction, and each being daily rendered more efficient by reduction of temperature and increase of duration, there ensues a neuro-vascular stimulation, which, repeated daily, refreshes the central nervous system, dilates the cutaneous vessels, deepens the inspiration, in short produces that therapeutic result which is summed up in the word "tonic." All these effects are the outcome of reaction after cold procedures. This physiological process is inaugurated by the effort of the organism to counteract the invasion of cold, and to re-establish the previous *status quo* which has been disturbed by the abstraction of heat from the skin. 'In proportion to the disturbance of the system is the response of the latter for its defence.' This is a trite physiological principle. It is a well known fact that mild excitation stimulates, and that intense excitation depresses. Applying this principle to excitation to nerves and vessels of the skin by cold, we find that brief applications produce a redness of the skin, showing a tonic dilatation of its arterioles, and a stimulating effect on



the central nervous system. This is the legitimate effect of a mild, rapid and evanescent application of water below the temperature of the skin.

"A more intense application of cold produces an atonic dilatation of the cutaneous vessels, which may be readily observed after prolonged application of ice. And true to the laws of physiology, the continued application of ice would destroy the vitality of the skin, resulting in frost bite.

"The dosage may be correctly accomplished by intermediate temperatures and methods, as is illustrated in its application to the still-born infant in ordinary practice.

"Moreover, the vasomotor system is under control of excitants applied at its distal end—the skin—through its sensory terminals and arterioles. The latter stand under the direct influence of the vasomotor center in the medulla. When this center is excited to reflex efforts, the smaller peripheral vessels contract in proportion to the intensity of the excitation. It is an accepted fact that the vasomotor center maintains the tonus of the vessels upon which the elastic resistance at the periphery depends, and which in turn regulates cardiac activity and blood pressure. That the circulation may be positively influenced by irritants applied at the periphery, has been again and again demonstrated, and that the excitant action of cold and heat is similar in effect to that of other irritants has also been clearly proven.

"The excitation induced by chemical, mechanical or thermic irritants differs only in degree. In hydrotherapy we are concerned only with the latter two. Besides the reflex effects, there is another no less potent influence exerted upon the heart and larger vessels by the local effect of cold water upon the cutaneous arterioles. The latter are contracted primarily, but after the withdrawal of cold water the blood returns and fills them to repletion. The redness of the skin

after a good hydiatic procedure testifies to this fact. A very important hydrotherapeutic truth is here in evidence, viz., that the dilatation of the arterioles following the brief application of cold is not a passive congestion, as is that which follows a long continued application, after which the skin assumes a purple or cyanotic hue. The latter is accompanied by coldness, the other by warmth. The proper reactive dilatation of the cutaneous arterioles which follows a proper application of cold water is correctly regarded as a tonic process which enhances the peripheral elastic resistance and thereby increases ventricular action, improves the radial pulse and thus drives the blood into all parts of the system, with a vigor which in chronic diseases involving the nutrition, must inure to the benefit of the entire organism. My own observations have confirmed the statements of Winternitz, Rovighi, Thayer of Johns Hopkins and others, that after an active cold hydiatic procedure there is a decided fluxion evidenced by an increase in white and red cells even in parts which have not been subjected to the direct influence of the cold, as the lobe of the ear or the finger tips. This increases from 10 to 25 per cent. and continues for several hours in a lesser degree. This daily excursion of cells from the interior to the periphery must increase oxygenation and its sequelae, haematosiis and nutrition, in a manner in which no medicinal agent is capable of inaugurating or maintaining.

"To sum up, it may be affirmed that the changes produced by the mechanical and thermic stimulation of that vast net work of nerves and vessels which ramifies through the skin impresses such changes upon the caliber of the vessels, the action of the heart, and consequently upon the distribution of the blood cells that all the organs must share in this improved circulation. The direct effect of the latter must include restoration of defective glandular activity and removal of

impaired nutrition, enhancement of elimination of toxic products which constitute the chief lethal factors in chronic disorders."

In answer to a direct question Dr. Baruch said:

"You know I am not a hydrotherapist, but a physician of regular standing, devoted to a private and hospital practice, and only using water as a potent auxiliary to improve the results in chronic diseases. It may interest you to note that in 1866 Prof. Erb wrote in his excellent work on *Locomotor Ataxia*, 'The undeniable influence of the water treatment upon tissue change, nutrition and body weight, upon the energy of the heart, and the general increase of strength and working capacity is established.'

"In the *Zeitschrift fuer Praktische Aertzte*, 1868, Professor Senator stated that 'the excitation of the cutaneous nerve terminals are physiologically the most efficient element of hydrotherapy.'

"Struempell states 'In the symptomatic treatment of Tabes these methods are indispensable.'

Bear in mind that these are views upon the value of water treatment in *Locomotor Ataxia*, a disease which but too often baffles our best efforts at palliation.

"Dr. Erb writes 'In the management of neurasthenia the water treatment is of the greatest value.'

"Even Collins, who inveighs in unwarranted terms against the 'hydiatist, lay and medical,' in writing of the treatment of nervous diseases, states 'Cold water is the most potent agency to stimulate the circulation and to facilitate metabolic changes; it promotes the appetite, facilitates digestion and overcomes myasthenia' and thus—lauds it more than does the hydiatist!'"

I wish I had time to quote further from the several hours talk, and the excellent papers of Dr. Baruch which I

was permitted to read on the subject, for I am aware that this is but an imperfect abstract of all that I have heard. I wish I might speak of the great work he has accomplished along the line of Public Baths since he made his first plea in this country for the rain baths, which he did in an editorial in the *Medical Times and Register* of Philadelphia August 24, 1886.

When I have visions come before my "mind's eye" of the over-crowded pool at Sutro's, or of the tiny wooden "tub" the size of an ordinary living room in connection with Bethlehem Institute in our own city of Los Angeles, which I have with my own eyes seen packed so full of small squirming mites of masculinity of every degree of nationality, health and personal habits, that they could hardly stir, the "unlearnedness of me" even, is aroused, and I am wondering if we cannot some how, some way, teach our poor, as well as our rich, how to bathe.

A great public rain-bath in Los Angeles where water, soap and towels would be free—absolutely free—and where even the carelessness of the attendant need not jeopardise the health of the man, woman or child who partook of the benefits, would go a long way toward "washing the map clean" down about Sonora-town, and might in time prove even to "Angelesños" that Godliness follows close after cleanliness.

Vidal, of France, reports eight cases of ulcerating lupus with tuberculous ulcerations of the neck or tuberculous arthritis of the knee all cured by systematic exposure to sunlight for several hours a day.

Strophanthus has been prescribed in several cases of goiter, ten drops of the tincture three times daily, with a rapid reduction in the size of the enlargement, and in every case a cure.

## THE POETICAL NOMENCLATURE OF HUMAN ANATOMY.\*

BY HENRY SHERRY, M.D., PASADENA, CAL.

There is beauty and poetry in all things if we but look for them. There is also a terse and repellent aspect, which we are often too prone to exaggerate into great difficulties. So true is this of Osteology, that where a subject presents apparent difficulties, it is a not uncommon expression to say it is "dry as a bone." While I grant you this as to its material character, bones have a beauty of form which the ancient anatomists, with an acuteness of observation and a veritable genius for imagery, have made of Anatomical Nomenclature a beautiful, symphonic poem. To fully appreciate this, however, you need to approach the study of it with that reverence and tenderness of touch that makes each tiny cell a priceless pearl.

Imagine then the ancient anatomical student approaching his first subject for study. He sees before him a body with four extended points, topped with a rounded eminence. The main part from which emanate the others he touches and says *truncus*—trunk. He touches the rounded eminence and thinks head, but writes *caput*. The extended parts being the ends of the body, he calls "outermost," and with his stylus writes *extremus*—extremity. Having removed the soft parts he comes to the dry framework, and exclaims *skello*—"I dry," and we say skeleton. He takes the head in his hands, and to his imagination it is similar to the head protection of a soldier, and he says helmet but writes *kranos*—cranium. He turns it over and behold, a large hole at the bottom into which he thrusts his finger and says "I pierce," but writes *foramen*, and because it is the largest hole he calls it *magnum*—foramen magnum. He then

fills this hole with perhaps wild oats, moistens them with water and sets the bony receptacle away for an indefinite period. Bye and bye he observes crooked lines verging here and there, and they seem like the pricks made with his thorn needle, and he exclaims *suture*—suture—"to stitch." He touches the forehead and says *frons*—frontis—the frontal bone. Turning it around to the opposite side he says *occipital*—from *oc.* *ob.* obverse—and *caput*, the head. Placing it between his two hands, the sides appear like a wall, and he exclaims "*paries*"—a wall—parietal.

His observations had taught him that the hair first becomes gray at the marginal sides and he wrote *tempus*—time—and we have temporal bone. For here the withering touch of time first marks us for his own.

The bones being now separated he finds one apparently driven between the others, and he exclaims *sphenoid*—from *spheno*, a wedge, and *eidos*, like—like a wedge.

Between the cavities for the eyes he finds a bone full of little holes, and he thinks of the basket woven from the rushes in which he shakes his grain to separate the wheat from the chaff, and he exclaims "*ethmoid*"—from *ethmo*, a sieve and *eidos*, like—sieve like.

From out the bony canal of the ear there drops into his hand, three pearls—*malleus*, shaped like a hammer or mallet, *incus*, shaped like a blacksmith's anvil, and *stapes*, shaped like the stirrup of a saddle. Passing downward to the trunk he finds a bone with a double curve, which seems to be a brace or key to support the shoulder and he says *clavicle*, from *clavis*, a key (do not confound this with *clavus*, a nail). He

\*Lecture delivered before the School for Nurses of the California Hospital, Los Angeles, February 6, 1906.



take the flat, bony protection of the chest with his mallet and says solid. But writes *sternum*, from "steros."

He sees the heart and lungs protected with bony strips, and he writes *custodire*—to guard or defend—and we have *costa*, a rib.

A flat, irregular shaped bone like a battle ax forms the shoulder, and he says *scapula*—shoulder blade. A rounded prominence at its upper margin he named acromion, from *achron*, summit, and *omos*, shoulder. At its apposite margin appears a curved process like a crow's beak, from *krane*, a crow, and *eidōs*, like, coracoid process. *Humerus*, means upper or most elevated part of the upper extremity. *Ulna* is from *olenē*, the elbow. *Olecranon* process of the ulna, is from *olene*, the elbow, and *kranos*, the head—the head of the elbow. *Condyle*—means a knot or knuckle. Styloid process is from *stylos*—a pen, and *eidōs*, as the ancients wrote not with a fluid but with a sharp pointed engraver's tool. *Radius* means a staff, a rod, or spoke. *Carpus* represents the appearance of a bunch of fruit with the eight bones of the wrist grouped together. 1. *Scaphoid*, a skiff. 2. *Semilunar*, half-moon. 3. *Cuneiform*, wedge shaped. 4. *Unciform*, hook shaped. 5. *Ox Magnus*, large bone. 6 and 7, shaped like a trapezium. 8. *Pisiform*, pea shaped. Meta carpus, from *meta*, after or beyond, and *carpus*, the wrist—after the wrist. Extending the bones of the fingers, they present the appearance of a row of soldiers, and thus we get *phalanx*, and say phalanges.

The vertebral column presents a series of processes, which from their resemblance to a row of thorns were named *spina*, "a thorn." The spinal column, from its adaptability to twist and turn, was named *vertebrae*, from *vertere*, "to turn." The first cervical vertebra as it sustained the head was named *Atlas*, from *atlo*—"I sustain,"

as Grecian mythology informs us that Atlas sustained the world upon his shoulders.

The second cervical vertebra, called axis, from the word *axon*, and means a right line passing through a body, just as the *odontoid* (tooth like) process passes between the arches of the Atlas. That part of the spinal column named sacrum, is from *sacre*—sacred or holy, because it protects the contents of the pelvis, which were considered sacred, and possibly also because it was offered in sacrifice.

The tip of the spinal column, from its resemblance to a cuckoo's beak, is called *coccyx*.

*Pelvis* is thus called from its resemblance to an ancient basin. *Femur* means "thigh." *Tibia*, a flute, and *fibula* comes from *figo*, "I fix," and means a clasp or brace.

*Tarsus* means the posterior part of the foot, and *meta-tarsus*—beyond the tarsus. The ankle is the *astragalus* and the heel is the *os calcis*.

The etymology of the word muscle is very much in doubt, but the most probable derivation is from the Greek *musin*, meaning to close or move. Muscles are grouped as extensors, flexors, pronators, supinators, abductors and adductors. *Extensor* comes from *ex*, "out of," and *tensor*, "to stretch." Extend to stretch out. *Flexor* is its opposite, and means to bend. Pronator comes from *pronus*, "to incline forwards." Supinator, from *supinus*, lying on the back. Abductor, from *ab*, from, and *duco*, to lead or draw—muscles that draw away from a central line. Adductor, *ad*, toward, and *duco*, to lead or draw. To draw toward a central line.

When I look in your faces the first object I see are your eyes. They open and close, blink and twinkle. The muscle that does this is the orbicularis palpebrorum, from *orbis*, circular, and *palpebra*, to palpitae, or keep in motion.

I next notice that there are wrinkles between your eyes. This muscle is the corrugator supercilii, *cor.*, with—*ruga*, a wrinkle, and *supercilia*—super, above and *cilia*, a hair. The muscle which brings the eyebrows together with wrinkles, and brings forth the expression supercilious.

To elevate the upper lip we say *levator*, to elevate; *labii*, the lip, *superiori*, of the upper, the elevator of the upper lip. Substitute inferior for superior and the same description applies to the lower lip. If I wish to be scornful, or sardonic, I elevate the upper lip and the wing of the nose, by use of the *levator labii superioris alaeque nasi*—elevator of the upper lip and wing of the nose. If I wish to close the mouth, I bring into use orbicularis oris, from *orbis*, circular, and *oris*, the mouth. When I laugh, the muscle *risorius* contracts. This is derived from *risum*, to laugh. When I eat I do so by grace of the masseter muscle, from *masso*, "I knead or chew," and from which is derived "to masticate." If I puff my cheek as though to blow a horn, I call in play the buccinator muscle, from *bukane*, a trumpet, to sound the trumpet, or blow your horn muscle, and when it is much developed we say the person is "cheeky."

The cavity of the body is divided into two compartments, by the muscle known as the diaphragm, from *dia*, through, and *phrasso*, "I close."

The large muscle of the chest is called pectoralis, from *pectus*, the breast.

The arm is raised by a triangular shaped muscle, which covers the cap of the shoulder and is inserted into the humerus, and from its shape, like the Greek letter *delta*, is called deltoid.

When the arm muscles are made tense, the thick protuberant muscle is called biceps, from "*bi*, two," and *caput*, the head, because it arises from two different points which become merged.

The word abdomen is from *abdere*, to conceal. The large muscle over its front is called rectus, meaning right or straight. It flexes the chest upon the pelvis and is always wounded in abdominal operations.

Upon the back is a broad, flat muscle, the latissimus dorsi. As its name would indicate, it is from *latus*, broad, flat, and *dorsum*, the back. Beneath it, running up and down the spine, is a muscle which bends the spine backwards and also keeps it upright, the *erector spinæ*.

On the front of the thigh is a muscle which, because of its extent, is termed *vastus*, from "*vast*," great.

The longest muscle of the body commences at the crest of the Ilium and courses down the thigh, finding an anchorage at the head of the tibia, the *sartorius*, from *sartor*, a tailor, and is called the tailor muscle, because it flexes the leg and rotates the thigh, which enables us to sit tailor fashion.

On the outer aspect of the thigh, lying side by side, are two muscles, so much alike that they are called the twin muscles, *gemellus*. They rotate the thigh outwards. The calf of the leg is formed by a thick fleshy mass called the gastrocnemius, from *gaster*, the stomach or belly, and *gemi*, twins—the twin-bellied muscle. Beneath it lies a flat muscle shaped like the sole of a shoe and is thus called *soleus*. The fish known as the sole derives its name from the same source.

All the muscles of the posterior part of the leg, converge into a large, white fibrous band, which is inserted into the *os calcis*, known as the ham string muscle, and is the muscle which supports animals when hung up after being slain for food. The ancients named it *Tendo Achilles*, because it was the only vulnerable point of Achilles, for if they severed the tendon he could not run.

If in this imperfect outline study of the beauties of anatomy I shall have

sweep away some of the prejudices against it as a study, and impressed you with the imagery of its nomenclature, it

it too much to ask you to pass it on to others who may come within the sphere of your tutelage?

## EUSTACHIAN CATHETERIZATION THROUGH THE MOUTH, WITH A REPORT OF AN ILLUSTRATIVE CASE.\*

BY HIRSH A. KETTER, M.D., LOS ANGELES, CAL.

Eustachian catheterization via the oral cavity is a method we meet with but very seldom in actual practice. I have met with only a few gentlemen who professed to use it. It is a method not to be recommended for the ordinary run of cases requiring catheterization, as the methods of Kramer, Delean and others, utilizing the nasal passages as a way of ingress, is much easier of performance and requires less time. But it is too valuable an adjunct to be deserving of the extreme neglect that has been accorded it. We meet with occasional cases in which the methods above named cannot be utilized on account of nasal obstructions, and for such cases it is very fortunate that we have recourse to the method under discussion.

The technique is not difficult, and can easily be acquired by any one skilled in the use of the rhinoscopic mirror. The oro and naso-pharynx and soft palate should first be anaesthetized. The patient then depresses the tongue with an ordinary depressor, the surgeon manipulates the mirror with one hand, and with the other hand inserts the catheter into the orifice of the eustachian tube, using for this purpose a metal or rubber catheter (I prefer silver,) which should be bent in a long curve at the distal end to almost 90 deg. from the shank. Then withdrawing the mirror and laying it aside, he can use that hand for the manipulation of the Politzer air bag, which should be armed with a rounded hard-rubber tip, which will fit

in and close, but not wedge in the orifice of the catheter. The principal difficulty lies with patients who cannot relax the palate sufficiently to afford a view of the naso-pharynx. This difficulty, when it exists, can usually be overcome by a little training and persistence, and the use of a local anaesthetic, though there are some cases in which it seems impossible to accomplish this. The palate retractor may be tried in such cases.

Incidentally it can be said that this method is cleaner and involves less danger of carrying infective material into the middle ear than when the catheter is carried through the nasal chambers. How often on passing a catheter through a nose apparently well cleansed, and withdrawing it again without forcing air through, may we find a plug of mucus obstructing its lumen.

The following case will illustrate about the class of patients to whom I would, and do, restrict the use of this method:

J. C., aged 38, farm hand. Presented himself for treatment of the right ear, which troubled him with "fullness," and "ringing," and "some pain" for two days past. Contracted a cold in the head one week before this, from which he has almost completely recovered. General health good. Has always had difficulty in breathing through the nose. The right tympanic membrane is bulging, transparent, slightly injected at the margins, and presents

\*Read before the meeting of the Western Section of the American Laryngological, Rhinological and Otolological Society held at Los Angeles, Cal., January 27th, 1906.



evidence of serous fluid behind it to the level of the umbo. Very little tenderness at the tip of the mastoid: Rinnè negative; temperature 99 deg. F. Simple chronic naso-pharyngitis, with some evidence of the recent coryza. Both of the middle and inferior turbinates are much enlarged; a cartilaginous and bony spur on the right side of the septum; deflection of the cartilaginous septum to the left.

Repeated attempts at Politzerization failed after the application of adrenalin and cocaine to the orifice of the eustachian tube; catheterization of the tube through either nasal chamber impossible

on account of the nasal obstructions. Catheterization through the mouth was tried, after cocainization, with perfect success and the tympanum inflated. This was practiced daily for a period of six days. Thereafter inflation became possible by the Politzer method, which was employed every other day for ten days, the patient making an uneventful recovery.

It may be added that the patient refused absolutely to have any operations on his nose, thereby exposing himself to the necessity of having the same method adopted in case of a recurrence of the middle ear inflammation.

## SCOPOLAMINE-MORPHINE ANAESTHESIA, WITH REPORT OF TWENTY-FIVE CASES.

BY Z. T. MALABY, M.D., PASADENA, CAL.

In May, 1900, Schneiderlin<sup>1</sup> first published his experience with a new method of general Anaesthesia produced by the aid of a combination of Scopolamine and Morphine. Since then a number of reports have been published in Germany and Austria and in this country by Ries<sup>2</sup> and Seelig.<sup>3</sup> As the method undoubtedly has great advantages, it will probably come into more extended use and the purpose of this paper is to present a series of twenty-five operative cases with the administration of scopolamine-morphine as an adjuvant in the administration of general anaesthesia.

Scopolamine is an alkaloid extract from the roots of *Hyoscyamus niger*. Its sister alkaloids are hyoscyne, duboisine, atropine and hyoscyamine. The best résumé of the physiological action of scopolamine is given by Steinbuechel.<sup>4</sup> He states:

1. Small doses raise blood-pressing by stimulating the vasomotor center. Large doses lower it by influencing the cardiac excitomotor mechanism.

2. Pulse usually slowed a trifle, but is ordinarily not influenced by small doses. Large doses cause a vagus pulse.

3. Cerebral cortex rendered less excitable when stimulated by the faradic current. Sleep is induced, but not analgesia.

4. Respiration not influenced by small doses. Large doses, slow respiration.

5. Sweat, mucous and saliva secretion markedly diminished.

6. Mydriasis.

7. Motor end-apparatus supplying the intestine paralyzed. Tone of the splanchnic increased.

8. Excreted by the kidney.

Kochmann<sup>5</sup> states that there has never been a death attributable to scopolamine. Dogs react to the drug exactly as do human beings. Yet a dose of thirty grains injected intravenously into a fifteen pound dog, does not kill.

The greatest difficulty has been found in determining the best proportion of the two drugs. If too much morphine is given, the effect on the heart becomes

dangerous. If too much scopolamine is given, a state of excitement is produced. The patient becomes restless. It is difficult to keep them quiet, but this excitement soon wears off. I have experimented on dogs weighing ten pounds to whom I gave fifteen times the dose used in the following reported cases figuring pound for pound, without fatal result to the dogs.

I use a tablet containing scopolamine hydrobromate grain 1-100 and Morphine grain 1-6, made by Sharp and Dohme.

My experience has taught me that this drug, like all therapeutical remedies, it is impossible to ascertain a uniform dose.

There is no reasonable objection to the use of scopolamine, hydrobromate and morphine in the doses recommended of 1-100 and 1-6 of a grain respectively. The recent experimental work of Crile shows that morphine lessens the intensity of many of the afferent nerve impulses reaching the vasomotor centres, as the result of stimulation of the peripheral nerves, and thereby lessens the susceptibility to shock. Scopolamine exerts a distinct influence in raising blood-pressure and thereby also aids in preventing shock. So, from the point of view of prophylaxis, the combination of the two drugs strongly recommends itself. Only he who has witnessed a series of ether administrations preceded by scopolamine-morphine injections can appreciate what a boon these drugs afford both to the patient and to the operator.

Ordinarily this tablet administered hypodermically one hour before the operation will produce the desired effect. In robust individuals I have found it necessary to repeat the dose one-half hour following the first injection and in subjects of weak resistances a small amount is preferable.

Scopolamine-morphine has been used in a wide range of operations. I have used this method of anaesthesia on twenty-five cases. The following is a list of the operations performed:

Appendectomy, 2; Appendiceal abscess, 1; Cystoscopy, 3; Extirpation of fibroid uterus, 2; Extirpation of testicle, 1; Laparotomy for pus tubes, 1; Plastic operations on cervix and vagina, 3; Ovariectomy, 2; Exploratory laparotomy, 2; Gastro-enterostomy, 1; Fistula in ano, 1.

Of these twenty-five cases none vomited or retched on the operating table and only three after going to bed. Nausea was never pronounced except in two cases. There is no occasion for dilating upon either the discomforts or the dangers attendant upon post-anaesthetic vomiting. They are well known. I can find no record of a series of general anaesthesia administrations followed even by approximately so small a percentage of vomiting, and if the preliminary administration of scopolamine-morphine did nothing else than lessen the liability to vomit, its use should be highly recommended.

But it does more. First of all, it markedly lessens the quantity of anaesthetic necessary. About four ounces of ether per hour of operation are used when the drug is administered skillfully and carefully. In a personal communication to me, Dr. T. L. Bennett of New York tells me that he uses about four ounces of ether per sixty minutes of anaesthesia and that for two-hour operations he requires about six ounces. This averages three and a third ounces per hour. We used barely a fraction over two ounces per hour. It has already been pointed out how great a desideratum it is to administer a minimal quantity of ether.

After the administration of scopolamine-morphine, the patients are in a peaceful state of mind, and go under the influence of the general anesthetic without passing through the general state of excitement. Salivation is almost invariably absent, thus adding another safeguard against aspiration pneumonia.

After their return to bed the patients lie absolutely quiet and awaken without the slightest excitation. After remaining awake for a short period, they usually doze off again, or at least remain quiet and peaceful. The first twenty-four hours following the operation is attended by much less pain and discomfort than in cases where scopolamine is not administered. These advantages:—Lessened amount of anaesthetic necessary, absence of salivation, avoidance of the stage of excitement, marked reduction in the liability to vomit, and quiet and freedom from pain after operation, have been confirmed by Tuffier of Paris, Israel and Dork of Berlin and by Robertson of our own country. (Robertson used Hyoscine instead of scopolamine.)

The post-operative symptoms became alarming in one case. A colored woman who was emaciated and exceedingly

nervous with a slight mitral murmur and some hypertrophy upon which a hysterectomy for a large fibroid was performed. Pulse became rapid and bounding, respiration slow and labored. Large doses of strychnia were given and after twenty-four hours all disturbing signs had disappeared.

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## OCULAR SYMPTOMS OF SUPPURATION IN THE NASAL SINUSES.\*

BY HILL HASTINGS, M.D., LOS ANGELES, CAL.

Dr. Hastings presented the following specimens for inspection and consideration:

1. A section of the temporal bone showing productive osteitis of aditus and antrum.
2. The temporal bone of a child at birth, showing the high position of antrum and exit of the facial nerve.
3. A metal cast of the ear, including the mastoid cells, cochlea and semi-circular canals.

The last specimen, he said, was one of many he had made, most of them having been failures, and was almost perfect. He said that he had made the casts after Politzer's method, but found it was necessary to bore a hole in the inferior semi-circular canal to provide

an air vent before pouring in the hot metal through the meatus. Otherwise the labyrinth was not completely filled. The child's temporal bone, he said, showed another point, namely, the mastoid—squamous suture, in which was situated the antrum. He wished particularly to state that it was a misconception to regard the antrum as a part of the mastoid process. It is rather a part of the middle ear, as was shown by the specimen. Furthermore this conception, which was by no means original, he said, is significant in getting a correct idea of inflammatory conditions of the middle ear. The general practitioner is apt to believe that when the "mastoid antrum" is involved in the course of a suppurative otitis,

\*Read before the meeting of the Western Section of the American Laryngological, Rhinological and Otolological Society held at Los Angeles, Cal., January 27th, 1906.



the ear trouble is then dangerous. As a matter of fact, he believed that the antrum, as a part of the middle ear, is inflamed in every case of suppurative otitis media. Its mucous membrane lining is continuous through the short aditus with that of the cavum tympani.

If this fact is generally known, the necessity for an early incision of the drum membrane will be more impressed on the mind of the general practitioner, as the best abortive measure against mastoid involvement.

#### DISCUSSION OF DR. HILL HASTINGS' PAPER.

DR. H. L. WAGNER, San Francisco:—The treatment of accessory sinus conditions was so important that all information relating thereto was very welcome. Kuntz of Germany was the first to do extensive work along this line. The conditions met with were, one, those due to inflammation; two, those acquired through transmission; three, those dependent upon mechanical insults. The locations of the different sinuses are such as to favor manifestation of eye symptoms. Contributions to the pathology of these conditions

were to be presented and the essayist was to be congratulated on his successful work.

\* \* \*

DR. F. B. KELLOGG, Los Angeles:—Dr. Hastings' paper would lead the speaker hereafter to be more suspicious of sinus involvement in ocular neuralgias. In these cases not only the eye but the nose was worthy of examination. Gave a brief case history of a patient who only a week ago had exhibited the necessity of such examinations.

\* \* \*

DR. F. C. WELTY, San Francisco:—Reported three cases having a bearing on the paper. One of a brain abscess with choked disk, accompanied by sinus involvement; two, an eye case with pus in the orbital cavity; three, eye pain due to nasal polyp. His experience had not led him to expect eye symptoms in all suppurative conditions of the accessory sinuses. As suppuration became more severe, they were more apt to appear.

\* \* \*

DR. HILL HASTINGS, Los Angeles:—Agreed that many of the chronic cases had no eye symptoms.

\* \* \*

\*At the meeting of the Western Section of the American Laryngological, Rhinological and Otolaryngical Society, held in Los Angeles, January 25, 1906, Dr. Hill Hastings read a paper entitled "Ocular Symptoms of Suppuration in the Nasal Sinuses." This paper cannot be printed at this time.

## DEPARTMENTAL

### DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTINGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

**THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.**—The importance of an early diagnosis in pulmonary tuberculosis is insisted upon by all who have to do with the treating of this disease, for it is well known that the curability depends very largely upon the time of its recognition.

The proper treatment of early tuberculosis will produce a cure in somewhere between 75 and 95 per cent. of cases. While the same treatment just as intelligently carried out cannot hope

to cure more than from 15 to 45 per cent. of those advanced; so, while early diagnosis makes tuberculosis one of the most curable of all serious maladies, a late diagnosis makes it one of the most hopeless.

While the discovery of the tubercle bacillus has had a wonderful epoch-making influence upon the history of tuberculosis, and while it has made it possible for us to discover the disease in a comparatively early stage, yet it has done much harm, because clinicians

have learned to depend less upon their own diagnostic skill.

The microscope has shown us that tuberculosis may be diagnosed much earlier than was formerly believed, but at the same time it has made many practitioners rely upon it for their diagnosis. It must be remembered that bacteriological examinations are for precision and confirmation of clinical findings, but that they should not be relied upon entirely for the diagnosis.

The clinician is a man who sees the case in all its varied aspects. The man who examines the chest is the one who should make the diagnosis. The microscope should not tell him whether tuberculosis is present or not, but only whether or not it is present in the open stage.

Clinicians should free themselves from the bondage in which they have been held. They should learn to examine chests and make their diagnosis independently, using the microscope simply to confirm. It should be remembered that one negative finding with a microscope, or a dozen negative findings, does not show that tuberculosis is not present. It simply signifies that tubercle bacilli are not found in the specimens of sputum examined.

There are certain types of tuberculosis which will run a course of months and often years and not show bacilli in the sputum. There are certain other types which run a course, now open, now closed, and unless the sputum is examined during the open stage the bacilli will not be found, even though present in the lung.

A careful physical examination, together with a painstaking clinical history, to one who is accustomed to dealing with this disease, will furnish evidence of the presence of tuberculosis in nearly every instance. There are not many diseases that can cause the symptoms of early tuberculosis. From time immemorial men have talked about apical catarrh, but we now know that

apical catarrh is nearly always tuberculosis, especially if it is limited to one apex. The old idea of apical catarrh affording suitable soil upon which tuberculosis is developed, no longer holds sway. We now know that the so-called catarrh is tuberculosis itself.

Every physician should acquaint himself with the sounds of a normal lung. It is not necessary that rales be present. A slight roughness or diminished inspiratory note, or a slight harshness, expiration being either prolonged or not, are the auscultatory signs usually present in early tuberculosis.

On percussion, if the finger is educated, there may be a slight resistance felt over the diseased area by the finger which is used as a pleximeter, the note may not be quite so resonant and the pitch may be slightly elevated. While this may not suggest much to the physician who is not in the habit of examining chests, yet to the trained diagnostician it suggests the probable presence of a tuberculous lesion.

Cough is not necessarily a symptom of early tuberculosis, it may be present or absent. If present, it will most likely show itself as a slight hack after laughing or talking or some exertion. The ordinary cough such as is usually attributed to tuberculosis is not found in the early stage of the disease.

In its incipient stage expectoration will most likely be absent, or if present, will be found in small amounts. Whatever expectoration is found, of course, should always be examined by the microscope, yet a negative finding should not disprove a diagnosis.

In all cases where these slight symptoms are found the temperature should be taken most carefully, and there is one thing that should be impressed upon physicians, and that is, that the taking of temperature at the time the patient is in the office, whatever time of day that might be, is absolutely worthless as a diagnostic measure. The only

thing of value is the two hourly chart extending over several days.

The symptoms usually complained of in the early stage are those of feeling tired, perhaps with slight loss of appetite, perhaps with a loss of a pound or two of flesh, and a failure to secure proper rest through sleep. Many a patient has been seen during this early stage and given a tonic with assurance "that nothing is the matter except that they are in a run-down condition." Such a clinical history as this with a slight rise of temperature amounting to one-half to one degree, with or without elevation of pulse, and the slight findings upon physical examination mentioned above, should make a diagnosis of pulmonary tuberculosis fairly positive.

The positiveness of the examiner will depend very much upon the frequency with which he examines chests. If he is accustomed to this he will be much more positive than if his experience is limited.

THE DUTY OF THE PHYSICIAN TO THE PATIENT WHEN A DIAGNOSIS OF TUBERCULOSIS HAS BEEN MADE.—When a diagnosis of tuberculosis has been made, no matter in what stage of the disease, it is the duty of the physician to inform the patient of the facts. That which gives the patient the opportunity for cure in pulmonary tuberculosis is the knowledge that he is tubercular, because if he knows he is tubercular he has an opportunity of doing those things which will aid in bringing about a cure. If he does not know it,

he goes on tearing himself down or re-infecting himself through ignorance and carelessness, and soon the splendid chance which he would have had for regaining health had he been informed earlier, has been taken away, and his chance for life has been decreased 25 or 50 per cent. and may be taken away entirely.

Since we now know that tuberculosis is communicable, it is our duty from another standpoint to tell the truth to every patient affected with this disease. The disease is spread through the expectoration. If the patient does not know that he has the disease he is very likely to go about carelessly scattering his expectoration, which dries and becomes dust, and is spread into the air, thence to be taken into the system of some other person, there to cause some new focus of the disease. The greatest cause of scattering infection is ignorance; of course, there are some patients who would wilfully scatter infection, but they are very, very few. So the prevention of this disease depends upon the patient knowing that he has tuberculosis, and taking the proper precautions which he cannot do unless the physician finding the lesion deals with him honestly and frankly.

The first steps then in the prevention of tuberculosis are early diagnosis, informing the patient of the presence of the trouble, and instructing him in the proper disposal of the bacillus-bearing discharges, and very fortunately these same measures are the ones which will offer the patient the best chance for cure.

## DEPARTMENT OF SURGERY.

CONDUCTED BY ANDREW STEWART LORINCIE, A.B., M.D.

REVERSAL OF THE CIRCULATION.—Carrel and Guthrie in the February *Annals* make a report from experimental work done in the Hull Physiological Laboratory on reversing the blood current by anastomosis

ing the artery with the vein supplying an extremity. The history of such experimental work shows the first to have been done in 1902 in the University of Lyons by Dr. Berard and by Carrel in the laboratory of Lumière



The femoral artery and the saphenous vein was selected, the proximal end of the divided artery being sutured into the distal end of the divided vein. These experiments were partially successful, and later, in the hands of Carrel and Morel, entirely so.

The object in view was physiological and surgical—the surgical object being the prevention of gangrene when the arteries become occluded or for any reason are unable to carry the red blood to the capillaries. The obstacles to the success of this procedure seemed to be (1) The valves; (2) Numerous anastomosing veins causing decrease of blood pressure; (3) Resistance of the capillaries. Theoretically these obstacles seemed insurmountable. But by actual experiment they proved but transient and the arterial current after the lapse of several hours flowed freely through the vein with an arterial impulse and returned from the periphery through the artery as dark venous blood. It is believed these experiments will lead to certain practical results and conclusions from work now under way and which will be offered in a later report.

#### ACUTE POST-OPERATIVE DILATATION OF THE STOMACH.—

Halstead, in the January number of *Surgery, Gynecology and Obstetrics*, discusses this subject and reports a case of his own following nephrorrhaphy. The patient was a young girl of 18. Nausea and vomiting with gastric distention, not yielding to lavage, developed at once and continued for five days, ending in death. Autopsy showed the stomach enormously dilated and extending to the pelvis. The duodenum was also dilated for its upper third, the intestinal canal being in collapse. The dilatation of the duodenum terminated sharply where the descending limb dipped under the peritoneum. (No stricture or band is reported as being found.) There was no peritonitis. Fagge in 1872 first described this se-

vere type of acute dilatation of the stomach. Thompson in 1902 reported five cases of his own and collected 39 others in which dilatation occurred from various causes.

Of the 44 cases collected, 12 followed surgical operations, 6 were upon abdominal organs, 3 upon the gall-bladder, 1 ovariectomy and 2 upon the kidney.

Reidel reports two cases of acute dilatation of the stomach following cholecystotomy, both of which recovered. He considers operating on the gall-bladder especially predisposing to acute dilatation.

Muller reports five cases, two of which came to autopsy. Many cases are overlooked. Following operation on the gall-bladder or kidney hyperemesis is not uncommon. The urine is frequently partly suppressed.

Robson and Moynihan reported two cases which recovered after acute dilatation. Gastric lavage and strychnia were used in the treatment.

Albrecht, who reported two cases and collected nineteen, believes the cause of the obstruction to be a constriction of the gut at the ligament of Treitz where the superior mesenteric artery crossed the intestine. The sagging of the distended stomach accentuated the angulation by dragging the jejunum downward toward the pelvis.

Halstead thinks there is a paralysis of the gastric wall which permits dilatation, since constriction has been found lower down in the jejunum. No doubt excessive handling of the stomach wall in gall-bladder operations may account partly for it, as often pyloric adhesions exist and must be broken down.

Unquestionably the symptomatology is that of ileus and should be so treated. Muller advocates postural treatment—elevating the pelvis, with gastric lavage and use of strychnia to physiologic effect. Complete rest of the stomach by rectal feeding. Morphia should be used for pain. In suppression or in case of ex-

trine fluid saline solution intravenous or per rectum should be used. Drainage of stomach by gastric fistula or gastric enterostomy in cases where milder meas-

ures are ineffectual. The author is mindful of the fact that prolonged surgical procedures in this class of cases are extremely hazardous.

## DEPARTMENT OF INTERNAL MEDICINE.

CONDUCTED BY DUDLEY ELLISON, M.D., LOS ANGELES.

**RECENT HYPNOTICS.**—Dr. A. Maass discusses veronal, isopral, and neuronal. Certain individuals seem to possess an idiosyncrasy for the first of these, in consequence of which the slumber produced is disturbed and does not seem to be restful, but in general, the advantages of this drug more than counterbalances its disadvantages. Isopral acts well in small doses, but if taken on an empty stomach is likely to disturb digestion. It depresses the activity of the heart and consequently should not be administered to persons with nervous or mental affections. Neuronal, on account of its considerable amount of bromine, is particularly active in conditions of mental excitation and confusion, and is a valuable addition to the list of hypnotic drugs. In the author's opinion, the perfect hypnotic is yet to be found; some of those which we already have, being impossible of employment hypodermically, while others produce evil after-effects but we have drugs which act similarly to chloral, which are much less toxic.—*The American Journal of the Medical sciences.* February, 1906.

**MARROW IN TREATMENT OF PERNICIOUS ANAEMIA.**—Dr. Menefries reports the case of a woman afflicted with pernicious anaemia, in whom the red cells were increased from 180,000 to 3,000,000, and at the same time the symptoms attributable to her anaemia were removed by marrow opotherapy alone. The favorable effect of the marrow, in the author's opinion, was due to the fact that the patient exhibited a

marked myeloid reaction (5 per cent. myelocytes). While quite important in other varieties of pernicious anaemia, the form of opotherapy is always indicated in this disease when even a slight myelæmia is present.—*The American Journal of the Medical sciences.* February 1906.

**REMARKS UPON CERTAIN STATES OF VASCULAR SPASM AND FIBROSIS.**—Hare contributes in *Therapeutic Gazette*, Dec., 1905, some valuable therapeutic, diagnostic and prognostic points on states of arterial hypertension—a subject of growing interest and of much practical import in the treatment of cardio-vascular and nephritic conditions.

Three types of arterial hypertension exist: 1. The result of spasm of the vessels due to prolonged nervous stress combined with irregular habits, food and drink. 2. Those in which in addition to the spasm there is fibroid change in the vessels. 3. Cases in which, after a prolonged hypertension, there develops low tension in which the arteries are relaxed and distended, resembling veins in their calibre and compressibility.

The first class speedily improve in the pulse tension by rest from violent exercise, business stress and stimulants, and the administration of the nitrites.

The second type responds to treatment readily if the spasm factor is uppermost, and slowly or not at all, if the fibroid change is most marked.

Hare cites in detail clinical cases of the third class in which after long

continued hypertension the heart begins to fail in rhythm and strength with a consequent drop in arterial pressure.

He calls attention to the very interesting point that during excessive peripheral resistance both the heart and the large arteries undergo hypertrophy and that beyond a certain point the vessels may relax and dilate as does the heart. He speaks of this as "rupture of compensation" of the arteries. Summary:

1. In case of high tension due to fibrosis the nitrites can be of but little value, and the iodides with rest and massage are needful.

2. Cases of very high tension are usually those in which the heart escapes sufficiently to help maintain the tension.

3. As fibrosis in the peripheral vessels increases, the muscles of the larger vessels undergo hypertrophy, as does that of the heart.

4. It is quite as possible for vascular compensatory hypertrophy to rupture as for the cardiac hypertrophy to do so.

5. This rupture of vascular hypertrophy often gives the heart a rest and permits it to recover from its fatigue, and so life is saved.

6. It is possible if the peripheral fibrosis is arrested for the vessels also to regain power and a general improvement to ensue.

7. The cardiac stimulants are not needed in these cases as much as rest and the skilful use of alteratives and vascular sedatives.

pital. Dr. Pantzer, on seeing the case, and recalling the other cases of spastic obstruction, advised the use of morphine with atropine. Flatus and feces were passed without further aid in a short time.

Murphy, in the *Jour. Amer. Med. Assoc'n*, January, 1896, describes enterospasm of the small intestine found during an operation on a painter undertaken for intestinal obstruction. After twenty minutes exposure to the air this expanded and consequently bowel function was restored.

In 1896, Long of Richmond, Va., reported two cases of this sort, which he called "Dynamic Ileus." In one case the ileum was contracted in two places and another contraction was found in the sigmoid. His second case was found associated with appendicitis and periappendic adhesions. Subsequent to the patient's recovery from the operation, he continued to suffer of repeated attacks of intestinal obstruction, which Dr. Long regarded as being caused by enterospasm.

Haidenheim in *Berliner Klinische Wochenschrift*, Vol. 34, 1898, according to Pantzer, in a review of the causes of intestinal obstruction in cases operated by him, mentions enterospasm as the sole cause in two cases. In one, he regarded the condition as purely a reflex neurosis, as there was no other assignable cause present. In the second case the enterospasm was associated with volvulus. In this case the pulse was found to be 51 and reflex vagus irritation naturally suggested itself as the cause of the enterospasm. Haidenheim mentions lumbricoides, intestinal adhesions, bands and scars, as possible causes of enterospasm.

Strauss, in the same publication, relates a case of chronic intestinal stenosis, operated upon twice for obstruction. Each time only enterospasm was found and no adequate local cause for it was discovered. This was finally proven to be hysteria and the corresponding treatment gave full relief.

**SPASTIC OBSTRUCTION OF THE BOWELS.**—In the *Indiana State Medical Society Transactions*, 1903, p. 145, Pantzer reports four cases of spastic ileus, seen by him, in living subjects, while performing abdominal operations for various conditions. He reports another case, which had been treated unsuccessfully for a week for obstruction. Operation was decided upon and the patient taken to the hos-



# SOUTHERN CALIFORNIA PRACTITIONER

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

Address all communications and Manuscripts to

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## EDITORIAL.

### OBESITY.\*

This work is particularly interesting in its treatment of the subject of obesity.

Weinrand of Wiesbaden says: "It is remarkable that in certain forms of obesity no diminution of the physiologic processes of combustion can be determined. Clinicians have noted two classes of cases (a) Those in which overeating and deficiency of muscular labor were the obvious causes of the accumulation of fat, and (b) Those in which even a normal amount of food resulted in accumulation of fat, and even with a decided diminution of nourishment it was impossible to bring about a reduction in weight. \* \* \* It is unlikely that an obese person requires less energy than a healthy person for the maintenance of his vital functions,

for normal activity of the heart, for the rest metabolism of the glandular activity and for the maintenance of body heat."

von Noorden says: "Accumulation of fat owes its origin to (1) By an increase of food above an average normal consumption; (2) By diminution of exertion (muscle laziness) with an average normal amount of food; (3) By a combination of superfluous food and diminished exertion.

"Every corpulent person has behind him a period of overnutrition; not perhaps because he has eaten more than others who have not become fat, but he has eaten more than his individual constitution and bodily functions enabled him to utilize."

von Noorden makes three grades of anti-fat diet, giving in details several schemes. In the first grade the diet may be reduced to about four-fifths of the normal requirement; in the

\*Diseases of Metabolism and of the Blood, Animal Parasites and Toxology. By Richard C. Cabot, M.D. instructor in clinical medicine in the Medical School of Harvard University. An authorized translation from "Die Diätetische Klinik," under the general editorial supervision of Julius L. Sallinger, M.D. D. Appleton & Co., Inc.

second grade to three-fifths (this may be very readily adapted to the mode of life of most patients so that they can follow their occupations without hindrance. The rapidity of cure depends upon the amount of physical exercise they take. "To the third grade of anti-fat diet belong the anti-fat cures in which the diet is less than three-fifths or even only two-fifths of the usual requirement.

"A diminution of food to about two-fifths of the usual requirement is looked upon as the utmost that may be wisely attempted in the obese patient. \* \* \* Experience appears to prove that in numerous patients the administration of large amounts of meat—equivalent to a high intake of albumin—is much better than small ones. Meat is not only the most important food for most persons, but also is the one most desired. Nevertheless, there are many corpulent women who dislike large amounts of meat, and in whom any anti-fat diet that consists largely of meat will certainly suffer shipwreck. But we must insist on not less than the minimum of about 100 grams of albumin. As a rule we attain the best results if the fats are limited as much as possible, and if somewhat more of the carbo-hydrates are permitted in the food. \* \* \* The opinion prevails that the intake of fluids favors the accumulation of fat. This is unquestionably incorrect. How easy and cheap it would be for the farmer if the administration of water favored fattening! On the other hand, the statement that anti-fat treatment is favored by limiting the amount of water cannot be pronounced unqualifiedly incorrect."

The advantage of using small amounts of fluids in anti-fat cures, the author

states, is due to the fact that many persons eat decidedly less when forbidden to take as much fluid as they have been accustomed to. Pliny, the younger, advised those who desired to become thin to refrain from fluids while eating, and even afterward, to drink but little.

Ebstein of Gottingen has the principle article on obesity in this work. He tells us that Lord Byron, who was himself quite fat, defined the condition as "oily dropsy." "I look upon obesity, gout and diabetes mellitus as well, as forming a single group of interrelated diseases whose basis I designate as a general disease of protoplasm resting on a hereditary predisposition." \* \* \*

"In the first stage the obese man is an *enviable* person, in the second a *ludicrous* one, and in the third a *pitiab*le one. Obesity if left to itself becomes a protracted disease, which, as a rule, shows a tendency to progress."

In life insurance the risk of the obese person is to be estimated with caution.

"Among other factors which render the prognosis more serious in obesity, I must particularly emphasize the fact that as it progresses, it makes the individual more and more sedentary. The obese individual is usually distinguished by a less irritable nervous system. One who has a great burden of body fat to carry about with him can hardly be expected to have developmental powers equal to those of persons not limited in this way."

We cannot enter into the treatment of obesity as given by these three authors except to say the methods given are clearly set forth and no doubt efficient. Obesity is a disease, a dangerous disease, and should be treated as thoroughly and carefully as any other.

## A TUBERCULOSIS HELPING STATION OR DISPENSARY FOR INDIGENT CONSUMPTIVES.

The philanthropic citizens and physicians of Los Angeles who are interested in rendering ineffective the danger which menaces the public health, from having in our midst an excessive number of indigent consumptives from the East, are about to see fulfilled another of their aims, which it is hoped, will be of efficient service, not only from the prophylactic but from the therapeutic standpoint.

This time it is the Southern California Anti-Tuberculosis League that is about to inaugurate, with the aid of the Medical College of the University of Southern California and the help of sympathetic citizens and professional men, a "helping station" for indigent consumptives.

The value of these "Fürsorgestellen" or helping stations, where indigent consumptives can not only receive medical attention and instruction in preventive measures, but proper food and nursing when needed, has been so thoroughly demonstrated, both at home and abroad, that the method as an efficient prophylactic and curative factor no longer needs arguments in its favor.

The College of Medicine of the University of Southern California places at the disposal of the League two rooms in its well equipped dispensary building on Buena Vista street—an admirable location for the work—and a committee of citizens from the directorate of the Southern California Anti-Tuberculosis League, consisting of Messrs. B. C. Boothby, J. M. Conlier, C. C. Desmond and J. H. Francis, have promised to

raise the necessary funds to enable the Tuberculosis Helping Station to carry on its work. The medical supervision of this Helping Station has been placed under the supervision of Dr. F. M. Pottinger.

It is not only gratifying but extremely creditable that the citizenship of our municipality should show this generous sympathy for the physical unfortunates who come to us in such large numbers from the East, but who come unfortunately, in such advanced stages of the disease and in such straitened material circumstances that cure is utterly out of the question for many of them. The Southern California Anti-Tuberculosis League is worthy of praise for this practical demonstration of its aims.

The next step is to educate the East as to its duty to the West, so that it will cease to send these far-advanced cases far from home, friends and comforts, to pass their last hours among strangers in a strange land.

## MUNICIPAL SHOWER BATHS IN LOS ANGELES

In this issue of the PRACTITIONER is printed an article on Hydrotherapy, which is a layman's interview with Dr. Simon Baruch on that subject. Miss Belle Sumner Angier, who contributes the paper in question, is much interested in the subject, but especially in that phase of it which has to do with the establishment of public rain or shower baths in the poorer and more densely populated portions of our city.

That the rain or shower bath is in every way a vast improvement on the tub or pool bath must be conceded by all who have ever investigated the subject.



That baths such as these are needed in Los Angeles, no person who has ever seen the inner life of the slum and tenement districts of Los Angeles, will deny.

That the baths would be appreciated by that portion of our population which most needs them, cannot be doubted.

These things being true, we trust the campaign in which Miss Angier is engaged will meet with the success so good a cause deserves.

In this connection, while on this subject, we print a letter from the man who may well be called the founder of the public rain baths in this country, Dr. Simon Baruch of New York, whose recent sojourn in our State, in the interest of the work to which he has given so much of his life, has in some way been misinterpreted.

Dr. Baruch writes us as follows:

"Paso Robles, Mar. 5, 1906.

"EDITOR SOUTHERN CALIFORNIA PRACTITIONER:

"My Dear Doctor—Will you do me the favor to correct a report which seems to have gone out, that I am located at and in charge of Paso Robles Springs. The fact is, I was consulted by the manager of the springs, with regard to organizing their resources into a health resort that would be equal in scientific methods and results to European health resorts, like Aix-la Chapelle, Aix-le-Bains, Gastein, Baden and others.

"I have long entertained a desire to see such a resort (distinct from the sanitarium idea) established in our own country, as an example for imitation and to demonstrate that there is no need for large numbers of our invalids to undertake a long journey and temporary expatriation for the purpose of regaining their health.

"In order to be entirely untrammelled in my views and actions, I have declined a fee, but volunteered to investigate and organize the Paso Robles Springs, climate and other therapeutic resources.

"I have spent several weeks in training a physician in hydrotherapy and balneology, and have brought out one of the attendants who has long been

in my service in the clinic and elsewhere, to facilitate my training of other attendants.

"I have spent two months here, and hope in a few weeks to be able to leave Paso Robles as a thoroughly organized health resort, that will be a source of pride to this State and country, and which will add to the therapeutic resources of my colleagues here who have been so generously sympathetic to our propaganda for natural therapy.

"With high esteem,

"Yours faithfully,

"S. BARUCH."

### A NOTABLE STEP IN THE PREVENTION OF TUBERCULOSIS.

The public health of any nation is intimately interwoven with its material prosperity because its wealth may be said to be only the expression of the physical and intellectual energy which is expended by its inhabitants. Any disease, therefore, that cuts off human beings just as they are about to engage on their life work proper, after the State has gone to the expense of rearing and educating them, subtracts from the material wealth of the land. There is no disease, and certainly no preventable disease, which is the cause of death of so many viable adults as the great white plague and there is, therefore, no disease that is the source of so much loss to the wealth of civilized countries, as is this great scourge.

In the United States alone the annual loss, through the needless sacrifice of 150,000 human lives yearly, is more than three hundred millions of dollars and in our own state of California the annual loss amounts to more than eight millions of dollars.

Any disease, and especially any preventable disease, that causes such a loss of life and treasure is worthy of official

recognition by a government. It is gratifying to know that the United States has enlisted itself in the anti-tuberculosis crusade and that henceforth in all Federal Buildings, circulars will be posted calling attention to means of prevention and making it obligatory for the heads of departments to report all employees afflicted with the disease, dismissal from the service being the penalty for non-observance of sanitary rules by such persons.

This official recognition and the widespread publicity that must necessarily follow from such an order—an order, by the way, in which President Roosevelt has personally interested himself—cannot do otherwise than exercise a most beneficial effect upon the anti-tuberculosis movement of this country.

#### GRACIOUS WORDS.

The *New York Medical Journal* for February 10th, under the title of "*The Advance of Medicine in Southern California*," says editorially:

"With the appearance of its January number the SOUTHERN CALIFORNIA PRACTITIONER entered upon its twenty-first year, and in an editorial article appropriate to the occasion our esteemed contemporary speaks of the great changes that have taken place in the southern portion of California during the period covered by its very creditable career.

"When the PRACTITIONER was founded, twenty years ago, says the writer, 'El Pueblo de Nuestra Señora Reina de los Angeles,' as the municipality now known as Los Angeles was then called, had a population of but little more than 15,000; now it has 200,000. There are more than 750 licensed physicians in the county. These facts betoken a tremendous advance in the general prosperity of the region, and they have been accompanied by commensurate progress in the condition of medical practice and

teaching. The College of Medicine of the University of Southern California was founded at about the same time as the PRACTITIONER. The achievements of that institution and of others connected with medicine in Southern California are familiar to us all, and not the least among the agencies that have contributed to the progress made in medicine on the Pacific Slope is the SOUTHERN CALIFORNIA PRACTITIONER. We may reasonably hope and expect for a further long and honorable career."

#### EUROPEAN INSTITUTIONS.

At the recent meeting of the State Federation of Women's Clubs at San Jose, Mrs. F. M. Pottenger read a paper entitled "Lessons to be Learned from European Institutions." Her address attracted a great deal of attention and favorable comment. She said in part:

"One day in the early autumn, I visited one of these free sanatoria for the poor. It was in the beautiful mountainous region near Vienna in Austria. Surrounded by wooded hills, with attractive walks and drives all about, the location itself was charming. We were greeted by the physician in charge, a kindly, studious looking man, who took us through the buildings consisting of reception hall, assembly hall, dormitories, bath and dining-room, liege hall, like a broad veranda where patients lie in their invalid chairs and breathe in the fresh, pure air and rest; the treatment rooms, everything simple and complete, but nothing elaborate, only the necessary conveniences for proper treatment. Here many cases are treated yearly and are sent home able to work, to care for themselves, to help others and cease to be a danger to the community.

"In Germany, there is a close relationship between the sanatoria and the state insurance companies; for it is to the interest of these insurance companies that men be able to work and thus be placed off from the list of those to be aided or supported. As a result of this sanatorium treatment, statistics show that from 70 to 80 per cent. are returned to their full working capacity.

"The first sanatorium, which was established in 1850 at Goehersdorf, was

a matter of ridicule, for tuberculosis was then considered incurable.

"Now, in Germany alone, from statistics published in 1905, there are 83 state sanatoria, 32 private sanatoria, 13 children's sanatoria and 51 for scrofulous children and those who are liable to become affected with tuberculosis.

"And what is the result of this grand work? In Prussia, as a result of the measures, both direct and indirect, against tuberculosis, there has been a marked decrease in the disease; and, if the disease should continue to decrease in the same rapidity that it has in the last quarter of a century, it would be extinct in 1927."

## EDITORIAL NOTES.

Dr. Henry W. Coe of Portland, Or., spent a short time in Los Angeles about the middle of March.

Dr. Mark A. Rodgers of Tucson, Arizona, was recently called to Los Angeles professionally.

Dr. F. S. Bascom of Salt Lake City has been taking a vacation in Los Angeles.

Dr. W. R. Livingston of Oxnard is spending several weeks in the hospitals of New York and Chicago.

Dr. T. E. Cunneane of Ventura has become a member of the City Board of Education.

Dr. J. V. Larzalere of Escondido spent a few days recently in Los Angeles.

We recently had a visit from M. W. Satterfield, who has for many years been connected with the Wesley Hospital of Chicago.

Dr. Hamilton Forline, who formerly occupied a chair in the Northwestern Medical College, Chicago, has located in Ocean Park, near Los Angeles.

Dr. J. L. Maupin and Dr. Montgomery Thomas of Fresno have, with their families, been taking a vacation at Coronado.

Dr. C. C. Valle, health officer of San Diego county, has appointed Dr. G. M. Bumgarner, deputy county health officer for the section outside of the city of Escondido.

Dr. Ray Ferguson, who has been a resident of Nogales, Ariz., for six years and is quite prominent in Republican politics, has been appointed superintendent of the Territorial Insane Asylum.

Dr. J. M. Crenshaw of Redlands sued the Sunset Telephone and Telegraph Company for \$1200 for services rendered to a lineman who was injured by a fall from a telephone pole. The doctor lost the suit.

Dr. Merritt Hitt, whose illness we mentioned in the last number of the SOUTHERN CALIFORNIA PRACTITIONER, has gone to Imperial, San Diego county, to recuperate. Dr. Hitt expects to be absent several weeks.

"Of all the cants which are canted in this canting world, though the cant of hypocrites may be worse, the cant of criticism is the most tormenting," wrote Laurence Sterne in *Tristram Shandy*.

Dr. W. J. Goodhue, physician at Molokai, has been working faithfully for the last few years searching for the bacillus leprae in animals other than men. It is believed by those who are in touch with his work that he will soon be able to announce the method by which leprosy is conveyed.

Dr. Wm. Freeman of Fullerton, Cal., celebrated the fortieth anniversary of his graduation as a practicing phy-



sician on March 6th. He had as his guests at a delightful banquet eighteen members of the Orange County Medical Society.

Dr. A. T. Holland of Los Angeles died March 6, 1906. He was sixty-three years old, a graduate of the Missouri Medical College and post-graduate of the College of Physicians and Surgeons, New York. He had been practicing medicine in Los Angeles for twenty years.

We have received the following monographs by Hill Hastings, M. D., of Los Angeles:

"Sinus Thrombosis. A Report of Two Cases, with Masked Symptoms."

"A Case of Cerebral Abscess of Otic Origin—Operation—Apparent Recovery—Relapse—Operation—Death—Autopsy."

No. 3, of Vol. II, of *Surgery, Gynecology and Obstetrics*, an international magazine published monthly, has reached our table. It is published by the Surgical Publishing Co., of Chicago, 103 State street. The managing editor is Franklin H. Martin, M. D.; associate editor, Allen B. Kanavel, M. D., with a large editorial staff and a long list of eminent collaborators. This is a very handsome magazine, liberally illustrated and containing articles of the highest importance to those who are interested in these three subjects.

Up to 1890, except in the universities of Oxford, Cambridge and London, the standard medical curriculum could be completed in four years. Now, owing to the introduction of further subjects of instruction, and to the fact that the severity of examinations has been generally increased, less than 30 per cent. receive their diploma in six years, and of the 715-10 per cent. who take over six years half are not qualified in seven. The average English medical student requires six and one-half years to obtain a license.

The San Bernardino and Riverside County Medical Societies held a joint meeting in Colton on March 14. Dr. T. C. Pounds read a paper on "Asthma;" Dr. O. J. Kendall of Riverside read a paper on "Stone in the Bladder;" Dr. Granville MacGowan of Los Angeles talked along the same lines. In the evening a banquet was served and Dr. W. B. Sawyer of Riverside read a paper, "Subject and Shadow." Dr. Woods Hutchinson of the Arrowhead Hot Springs spoke on "The Relation of the Physician to the Public."

The status of cremation in the civilized world can be readily understood from the following table:

Country.	No. Cremations.	No. Incinerations, 1901.
Germany .....	7	693
England .....	7	445
Italy (a) .....	22	243
Switzerland (b) .....	3	144
Sweden .....	2	..
Denmark .....	1	34
Paris .....	1	207
United States (c) .....	26	3695
Total .....	69	4461

(a) In 12 only. (b) In 2 only. (c) In 24

Dr. J. B. Murphy of Chicago has been visiting Phoenix, Arizona. The "Daily Republican" of that city says: "It is probably due to the suggestions of Dr. Murphy more than any other person that Phoenix climate has become famous throughout the United States, and it is likely that he has practically sent more patients to Phoenix than any ten other men in the medical profession." Dr. Murphy stated to a reporter that practically no visitors from the far east were in Florida, and Chicago, which usually sends them by the train loads, also failed to respond. The travel to Cuba, which formerly was by way of Florida, is now by way of New Orleans. While in Phoenix Dr

Murphy was the guest of Dr. R. W. Craig.

Cuban pharmacies have great difficulty in obtaining good clerks. The pay is \$25 to \$100 per month. They are free three times a week after 6 p.m., and also every second Sunday. Pharmacies are open from 6 in the morning until 10 or 11 at night, Sundays included. The educational requirements of pharmaceutical students are as follows: The prospective student must first go through the whole course of the high school, the same as engineers, lawyers, etc. He must also put in four years at the university, and then stand a practical examination in materia medica, some microscopical examinations, in Galenical pharmacy, all the United States Pharmacopeia, including chemistry and the full qualitative analysis and all the analytical parts.

Among the articles in the Miscellaneous Department of this issue of the *PRACTITIONER* appears a paper on "The Poet Crabbe as a Physician," and therein are given some of his pen pictures in verse, of the quacks of his day. His description, written a century ago, is still applicable to modern charlatans, who if anything, have increased in numbers and resources with the passing of time, as witness the following item taken from a recent issue of the *Los Angeles Times*:

"WASHINGTON, March 25.—Orders have been issued by the Postmaster-General instructing the postmasters at New York and Brooklyn to refuse to admit to the mails the advertisements of fifty-two illegal 'medical offices,' located in those cities, and also to refuse to deliver mail matter received addressed to the fictitious and assumed names under which parties conducting these concerns hide their identity.

"This action at New York and Brooklyn is in line with the efforts previously made by Postmaster-General Cortelyou in Boston and Philadelphia to enforce the law against this class of criminal concerns. A statement given out at the Postoffice Department, today, says:

"The condition of affairs which has developed under the department's investigations in all of these cities has been appalling. It was found that in a large number of instances those engaged in conducting these offices have criminal records, and are 'dope fiends.' In Boston, one of the concerns excluded by the department from the mails was supposed to have been the office at which was performed the fatal operation upon the young woman, Susan Geary—the 'suit-case murder.' One of the 'doctors' whom the department found identified with several of those 'offices' in Boston was also connected with the Susan Geary case. The number of deaths that have been caused in these offices will never be known."

"The volume of business done by these concerns was large. It was said that as high as twenty criminal operations a day were performed in some of these offices, and that the income sometimes ranged as high as \$2000 a week."

## SOCIETY TRANSACTIONS.

### MEDICAL SOCIETY OF THE STATE OF CALIFORNIA.

#### OFFICIAL ANNOUNCEMENT OF FIFTIETH ANNUAL MEETING.

The next annual meeting of the State Society will be held in San Francisco, the entire week, beginning Tuesday morning, April 17, 1906. The Rocky Mountain Interstate Society, the Pacific Branch of the Urological Society, and of the Ophthalmological and Oto-Laryngological Society will combine with the

general and section meetings of the State Society. The scope and interest of our meetings will be thereby very much enhanced.

The Committee on Scientific Work would particularly draw attention to the series of Clinics which have been arranged for the mornings of Friday, April 20th, and Saturday, April 21st, at the various hospitals, which includes:

Syphilis in all its manifestations, Tropical Diseases, Medical Cases of Interest, General Operative Surgery, Genito-Urinary Surgery (Cystoscopy Ureteral Catheterization, etc.), Eye, Ear, Nose and Throat Clinics. An abundance of rare and interesting material has been collected at considerable effort, and we would especially urge members to arrange to continue their stay over the morning of Saturday, April 21st.

The Committee would further announce that the following time limit has been placed on all contributions: Orations, thirty minutes, scientific papers, fifteen minutes, discussion, five minutes. A bell will be rung in each case, one minute before the time expires.

Members finding subjects of interest in the papers below, will please send their names and choice of subjects to the chairman of the Committee, that they may be called upon to enter into the discussions.

Committee on Scientific Work—Harold Brunn, M. D., chairman, 1312 Van Ness avenue, San Francisco; C. M. Cooper, M. D., Philip King Brown, M. D., Philip Mills Jones, M. D., W. Francis B. Wakefield, M. D.

#### RAILROAD RATES.

*The following arrangements have been made in regard to railroad rates for the April meeting:*

*A round trip rate of one fare and a third on the receipt certificate plan; going tickets on sale ten days prior to the opening date of the meeting. Be sure and take a receipt-certificate when you buy your ticket to San Francisco. If you buy the lowest fare first class limited through trip ticket, no stop over will be allowed; no stop over will be allowed in any event on the return trip. If you wish to stop over, buy an unlimited going ticket, which will cost a little bit more than the strictly limited ticket. The receipt certificate must be signed by the Secretary in order that you may secure*

*the one third return fare. Returning tickets may be purchased on or before Tuesday, April 24th.*

#### BANQUET

No arrangements have yet been made in regard to the banquet. It will be a matter of voluntary agreement on the part of those who desire to attend. It will probably be held Thursday night. No toast list has been made up.

Some years ago the State Society by resolution decided to abolish the practice of large and expensive banquets being given by the local profession of the place where the Society happens to meet; consequently, anything of this sort must be a purely voluntary matter.

#### PROGRAMME

The scientific work will be divided among the sections as follows:

1. Section on Medicine, Pediatrics and Obstetrics.
2. Section on Surgery and Gynecology.
3. Section on Urology, Syphilis and Skin Diseases.
4. Section on Eye, Ear, Nose and Throat.

These sections, as already noted, will hold joint meetings with the Rocky Mountain Interstate Society, the Pacific Branch of the Urological Society and the Pacific Branch of the Ophthalmological and Oto Rhinological Society.

The forenoon sessions will begin at 10 and the afternoon sessions at 2 o'clock. Tuesday morning, the 17th of April, will be given over to the address of welcome and the reports of officers. Subsequent sessions will be devoted to scientific work. The programme naturally attracts a much larger number of essayists from the northern than from the southern part of the State, but among those from the South who are to read papers are the following:

*"Report of Committee on Tuberculosis"* by Dr. F. M. Pottenger.



"What is Rheumatism" by Dr. Woods Hutchinson.

"Further Report upon the Surgery of the Prostate Gland for Prostatic Obstruction in the Old, Based upon Personal Observation in 140 Cases of Prostatectomy," by Dr. Granville MacGowan.

"Xanthlasma Palpebrarum," by Doctors Thos. J. McCoy and A. C. Rogers.

"Recognition, Prevention and Treatment of Complications in Anaesthesia," by Dr. Frank D. Bullard.

"Some Unusual Cases of Sepsis," by Dr. W. W. Roblee.

"Spasmodic Torticollis," by Dr. P. C. Pahl.

"Diagnosis of Diseases of the Stomach," by Dr. L. G. Visscher.

"Indications for Surgical Interference in Stomach Diseases from the Physician's Standpoint," by Dr. George L. Cole.

"Indications for Surgical Interference in Stomach Diseases from the Surgeon's Standpoint," Dr. J. DeBarth Shorb.

"Medical Defense," by Dr. W. S. Fowler.

"Compulsory Registration and Fumigation, the Most Important of all Measures in the Prevention of Tuberculosis," by Dr. George H. Kress.

The regular programmes of Tuesday, Wednesday and Thursday will be continued over to Friday morning, when there will be important Clinics at nearly all of the large hospitals in general operative surgery, in genito-urinary work, in orthopaedic and in eye, ear, nose and throat work.

On Friday afternoon there will be a joint session with the Rocky Mountain Interstate Society and on Saturday morning medical clinics will be held at the city and county hospital.

Members who intend to attend the State meeting at San Francisco will confer a favor by telephoning the Secretary of the Los Angeles County Medical Association, as it may be possible to have a private car for the party.

### CALIFORNIA PUBLIC HEALTH ASSOCIATION.

The Sixth Session of the California Public Health Association will be held at San Francisco, April 16, 1906.

The programme is as follows:

10 a.m., Greeting by the President.

10:30, "The Condition of California's Water Supplies," by Dr. N. K. Foster, Secretary of the State Board of Health.

Noon recess.

1:30 p.m., Address by George C. Pardee, Governor of California.

2:30 p.m., "The Sanitary Quality and Purification of Public Water Supplies," by Professor Hyde of the University of California.

3:30 p.m., "Sanitary Disposal of Sewage," by George L. Hoxie, City Engineer of Fresno.

4:30 p.m., one hour devoted to questions and answers on any subjects.

Each paper will be open for discussion immediately at the conclusion of its reading.

The discussion of the subject of Sanitary Disposal of Sewage will be opened by Dr. Clark of Willits.

At 4:30 questions on any matters may be brought up and discussed.

In the evening the Association will meet at the banquet board, when short addresses of a general character will be given.

The officers of the California Public Health Association are President, Dr. Edward von Adelung of Oakland; Vice-President, Dr. Wm. Simpson of San Jose; Secretary, Dr. N. K. Foster of Sacramento.

### AMERICAN CLIMATOLOGICAL ASSOCIATION.

The annual meeting of the American Climatological Association will be held on May 12-14th, at Atlantic City, at

the new "Marlborough Blenheim," which will be the headquarters of the Association.

Members will notice that the dates for our meeting immediately precede those of the Association of American Physicians at Washington, May 15th and 16th, and those of the National Association for the Study and Prevention of Tuberculosis at Washington, May 17, 18 and 19th.

Further information as to local arrangements can be obtained of Dr. Philip Marvel, Chairman, Atlantic City.

Additional titles of papers should be sent as early as possible to the Secretary.

GEY HINSDALE, M.D.,  
Hot Springs, Va.

## LOS ANGELES COUNTY MEDICAL ASSOCIATION.

### DIRECTORY.

The Los Angeles County Medical Association meets every Friday evening at eight o'clock in the Art Hall of the Blanchard Building, 233 South Broadway. (Home Phone, Exchange 83).

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One meeting of each month is designated a clinical evening. Members who can present case reports, specimens or patients for this meeting are urgently requested to notify the Secretary or President.

\* \* \*

Members who have in preparation, papers that would be of interest to the Association, should notify the Secretary or President, so that they may be placed on the programmes.

\* \* \*

The officers of the Association to whom communications bearing on their respective work, may be sent, are as follows:

President—Fitch C. E. Mattison, Stowell Building, Pasadena.

Vice Presidents—Adelbert Fenyes, Frank W. Thomas, W. W. Murphy, Homer O. Bates, M. L. Moore.

Secretary—Raymond G. Taylor, Bradbury Building, Los Angeles.

Treasurer—John C. Ferbert, Bradbury Building, Los Angeles.

Councilors—E. W. Fleming, W. Jarvis Barlow, C. G. Stivers, W. W. Beckett, Rose T. Bullard, B. F. Church, J. M. King, R. G. Taylor, L. S. Thorpe, F. C. E. Mattison, Frank Garcelon, George L. Cole, Claire W. Murphy, Stanley P. Black.

Trustees—Walter Lindley, J. M. King, R. G. Taylor, F. D. Bullard, J. H. Seymour.

Membership Committee—L. M. Powers, chairman; W. D. Babcock, E. R. Smith.

Medico-Legal Committee—Lewis S. Thorpe, chairman; William M. Lewis, Adelbert Fenyes.

Legal Committee—Albert Soiland, chairman; Frank D. Bullard, Adelbert Fenyes.

Committee on Public Health—W. W. Beckett, George L. Cole, Stanley P. Black.

Pasadena Branch—Adelbert Fenyes, chairman; J. E. Jones, clerk.

Pomona Branch—F. Thomas, chairman; G. G. Toland, clerk.

Long Beach Branch—Homer O. Bates, chairman; J. M. Holden, clerk.

Los Angeles Eye, Ear, Nose and Throat Section—W. W. Murphy, chairman; Hill Hastings, clerk.

Los Angeles Obstetrical Section—M. L. Moore, chairman; J. H. Seymour, clerk.

### MEETING OF MARCH 2, 1906.

This was an X-Ray meeting and was devoted largely to the inspection of skiagrams and the case reports connected therewith.

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Dr. M. R. Toland presented skiagraphs as follows: 1. Almost complete ankylosis of knee due to rheumatism; 2. Fracture of tibia and fibula with malunion and the same after wiring operation; 3. Iron fragment in hand; 4. Per-

ioistitis of head of femur; 5. Tuberculosis of hip joint in young man.

\* \* \*

DR. ADELBERT FENYES showed the following radiographs: 1. Normal chest; 2. Stone in kidney; 3. Murphy button in pelvis; 4. Heated tubercular focus in lung with adhesions; 5. Kidney stones; 6. Mediastinal tumor; 7. Chest of child; 8. Dislocated vertebra.

\* \* \*

DR. J. T. RANKIN presented the plates of a fracture of both bones of the forearm.

\* \* \*

DR. ALBERT SOILAND read a short paper on the status of Radiotherapy as viewed from results obtained in six years' work with these agents, during which time he had treated and kept under observation more than 300 patients. Referring to chronic skin lesions, he stated that surgical extirpation or galvano-cautery or pastes might be of service in lesions situated on fleshy portions of the body but they could not be compared in results, to X-ray when lesions were situated in places where skin was thin. Good results in these chronic skin lesions as epithelioma and lupus had been generally good except in patients who were debilitated or very old. He presented a large number of very interesting and instructive "before and after" photographs, which were thrown upon a screen by a stereopticon. Among the photographs presented were the following:

#### GROUP A. SKIN LESIONS:

1. Indolent rodent ulcer near ear, half of which had been destroyed. Under X-ray had obtained a clean wound in three months.

2. Rodent ulcer of scalp; 15 to 20 exposures; good result.

3. Epithelioma of forehead; 12 exposures; no visible scar.

4. Epithelioma lower eye lid.

5. Epithelioma upper eye lid.

6. Epithelioma lower lip.

7. Keratosis lower lip.

8. Lupus of nose (2 cases).

9. Destructive ulceration of half of nose.

10. Epithelioma of palm of hand (2 cases).

11. Hypertrichosis of arms.

12. Chronic ulceration following gas-oil burn.

#### GROUP B. BONE LESIONS.

1. Fracture of Cancroid Process.

2. Tubercular inflammation of head of humerus.

3. Fracture of clavicle and humerus.

4. Normal adult hip.

5. Impacted fracture head femur (2 cases.)

6. Double congenital displacement head of femur in boy.

7. Head from 44-calibre bullet scattered in tissues of foot.

8. Needle in foot.

9. Tuberculosis bones of hand.

10. Absence of second set of teeth in young woman.

11. Non-union of tibia and fibula.

#### DISCUSSION OF REPORTS AND SKIAGRAMS.

DR. F. C. MATTISON:—Inquired as to frequency of X-ray burns, their prevention and their treatment.

\* \* \*

DR. A. SOILAND:—There was no excuse for a sloughing burn. Burns to extent of hyperaemia and scaling of epidermis was what was sought in X-ray therapy, since stimulation and curative effects were largely connected therewith. Replying to a query in regard to the curative action of the rays, stated that the exact morphological and physiological phenomena involved had not as yet been satisfactorily established, that therapy sought to induce stimulation without allowing this to go on to stasis of the local circulation, or to tissue disintegration. Answering a question as to its value in chest diseases, stated that Williams of Boston and Abrams of San Francisco had done some excellent work along that line, but that much was yet to be desired.

\* \* \*

DR. J. T. RANKIN:—Referred to the discovery of the Roentgen rays about ten years ago, and the fact that they were for some years in the hands of the physicists. X-ray therapy had only assumed a distinct place for itself during the last four or five years. It was unfair therefore to ask too much of



it, but enough had been demonstrated to show its great value and possibilities.

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DR. M. TOLAND: Stated that for successful work it was necessary to know methods and to be familiar with the apparatus.

\* \* \*

DR. WERNICK: Felt that in chest work good results could be obtained with the fluoroscope and that the screen was by no means absolutely necessary.

\* \* \*

DR. P. C. PAHL: Referred to the advantages of X rays in fracture work. In the extraction of needles, by taking skiagraphs at different angles the foreign particle could be exactly located, and the surgeon had then only to cut down upon it crosswise, to find it.

\* \* \*

DR. F. C. MATTISON: Felt the Association was warranted in feeling a pride in the excellent pioneer work of its members along these lines. As to X-ray burns he had gotten results in their treatment with digestants of the class of enzymol.

#### MEETING OF MARCH 9, 1906.

This evening was given over to three papers on *Obesity*, *Lithaemia* and *Diabetes Mellitus*, respectively read by DOCTORS P. H. SUNDE, J. B. COOK and HARRIS GARCELON.

These papers will be printed in subsequent issues of the PRACTITIONER.

#### MEETING OF MARCH 16, 1906

DR. JOHN B. MURPHY of Chicago, Ill., delivered by invitation, an address on *Nerve Surgery*. His remarks were a preliminary report on some research work and investigation which he has been doing in the last two or three years, and at his request, since he will report his work in a paper before the American Surgical Association meeting of this year, the PRACTITIONER does not publish a synopsis of his remarks.

In a brief but very lucid manner, he considered the neuron theory and its bearing on degeneration and regeneration of nerve fibres, both in peripheral or lower segments and in the central or upper segments of the motor and sensory pathways of the cerebro-spinal nervous system. His views concerning the functions of the various parts of

the neuraxons and his reasons for holding to such opinions were presented most clearly and entertainingly.

No less startling in a sense, were his applications of these theories and abstract investigations to the applied surgery of peripheral nerves. The case histories to which he referred were instructive and very important from the clinical corroboration they gave to his theoretical premises.

\* \* \*

#### DISCUSSION OF DR. JOHN B. MURPHY'S PAPER

The discussion of Dr. Murphy's paper was participated in by Doctors Brainerd, Eckert, Boufford of Chicago and Lohrman. These gentlemen expressed their pleasure in having had the privilege of listening to a most stimulating address, acknowledged their acquiescence in the premises, conclusions and applications advanced by Dr. Murphy and confessed their inability to critically judge his remarks. In that his investigation had carried him into fields in which they had not yet entered.

Dr. Mattison, on behalf of the Los Angeles County Medical Association, thanked Dr. Murphy the thanks of the Society for his courtesy in presenting to it a line of work that bids fair to open a new vista in nerve surgery.

#### MEETING OF MARCH 23, 1906.

DR. Z. T. MALABY of Pasadena read a paper entitled "*Immediate Repair of Lacerations of the Cervix and Perineum at Labor*."

The essayist stated that in general practice, lacerations of the pelvic floor took place in about one-third of all primiparous labors and in about one-fourth of all subsequent labors. In skillfully conducted labors, the proportion should scarcely exceed 15 per cent. The types of laceration were discussed and immediate repair was advocated as the rule. The technique of immediate and secondary repairs was gone into in detail and the procedure in after-treatment also carefully outlined.

As to laceration of the cervix there was what might be called a normal laceration of the vaginal portion of the cervix in all primiparae and also in some

multiparae. Only when these tears are excessive do they gain pathological importance, as for instance, when a laceration extends upward to the vaginal vault and above it or when it is accompanied by considerable hemorrhage. The symptoms, diagnosis and treatment of these pathological tears were then considered.

As illustrating the necessity of a careful vaginal examination, if hemorrhage is profuse and the uterus is contracted, three interesting case histories were given, in two of which the cause was found, but in the third, a fatal case, even a postmortem failing to reveal the site or nature of the lesion to which the hemorrhage was due.

#### DISCUSSION OF DR. Z. T. MALABY'S PAPER.

DR. T. G. DAVIS: Immediate repair of tears of perinaeum and cervix not always satisfactory. Most lacerations of perinaeum are unavoidable. Most tears of cervix dependent on edoema from long continued pressure of head. Lipped appearance of cervix may be found in women who have never been pregnant.

\* \* \*

DR. JOHN FERBERT: Have gotten unsatisfactory union in 30 per cent. of my attempts at repair. Tears involving rectum are especially difficult. In joining sphincter ends, had found perforated shot excellent. Do not tie too tight a suture as it will cut out. Tissues swell and loose suture becomes taut. Immediate repair difficult because necessary assistants are not at hand. Referred to case where labor was induced at eight and one-half months because of contracted pelvis. Source of continued hemorrhage, which hemorrhage resisted styptics and packing, could be found neither during life or post mortem. Patient bled easily but haemophilia was not present.

\* \* \*

DR. W. JARVIS BARLOW: Thought it detrimental to tell patients of a cervical tear, if it was no more than what was normally to be expected.

\* \* \*

DR. M. L. MOORE: Thought Dr. Barlow's words about knowledge of a tear making a woman nervous, worthy of remembrance, but cited a recent case where there was a normal cervical tear but where a year afterward the patient had seen a physician in another city, who had insisted on operation for a bad cervical tear. Re-examination of tear showed it to be a normal one. Best, therefore, to mention a slight tear, so as to prevent an

unscrupulous practitioner from subsequently putting you in a bad light.

Thought we delivered through the cervix too rapidly. The same care at prophylaxis in regard to tears should be taken at cervix as at perinaeum. If forceps necessary, do traction gradually and intermittently.

Some women tear in spite of all efforts at prevention. Patient should be always cautioned not to bear down too much at these stages of labor.

\* \* \*

DR. L. D. JOHNSON: Believes that anaesthesia and stretching of perinaeum while under anaesthetic aid greatly in prevention of tears.

\* \* \*

DR. E. FOLLANSBEE: Agreed that anaesthesia, stretching of perinaeum and sharp "ah!" from patient to prevent bearing down were valuable prophylactic measures.

\* \* \*

DR. Z. T. MALABY: Thought it was wise to make an examination of the cervix, while waiting for placenta to be delivered. As regards operations for repair, especially when sphincter was involved, a good nurse and careful attention to after-treatment was of the first importance. Believed that almost complete anaesthesia at the time when the head was born was desirable. Perinaeum should always be examined for internal tears by eversion of vagina through rectum.

—

DR. PAUL C. ADAMS read a paper entitled "*The Induction of Labor, with a Review of 181 Cases of Induced Labor at the Sloane Maternity Hospital, New York City,*" which paper will be printed in a subsequent issue of the PRACTITIONER.

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#### MEETING OF MARCH 30, 1906.

By invitation, DR. ALFRED I. BOUFFLEUR, Associate Professor of Surgery at Rush Medical College, read a paper entitled "*The Role of the Peritoneum and Lymphatics in Abdominal Surgery,*" which paper we hope to present in a subsequent number of the PRACTITIONER.

\* \* \*

DR. CHARLES D. LOCKWOOD read a paper entitled "*The Treatment of Intestinal Obstruction, with an Illustrative Case,*" which will be printed later.

## MISCELLANEOUS.

## THE POET CRABBE AS A PHYSICIAN.

The celebration of the sesquicentenary of the birth of Crabbe the poet, at Aldeburgh, has, the *Lancet* remarks, attracted some attention to his career as a physician. Crabbe is much more read even in the United States than one would infer from the *Lancet's* insinuation that he has dropped out of perusal by the multitude. In the cheap edition which implies considerable circulation and perusal Crabbe still appears and delights a much larger circle than he did at the height of his boom. Ebenezer Elliott, the "corn-law rhymers," was of opinion that Crabbe's realism must be repugnant to the Americans. "Crabbe," he remarks, "takes his hideous mistress in his arms, and she rewards him with her confidence by telling him all her dreadful secrets. The severity of his style is an accident belonging not to him but to the majesty of his unparalleled subject. Hence it is that the unhappy people of the United States of America cannot bear to read Crabbe. They think him unnatural, for he is so to them, for in their rigid country, cottagers are not paupers—marriage is not synonymous with misery."

George Crabbe was born in Aldeburgh, Suffolk, England, December 24, 1754. His family, while in competent circumstances, were not as a rule highly educated. His father could barely read because he indulged in a preference for the ball. Crabbe was sent to school at Bimingham in order that his literary predispositions, which had already attracted attention, should be developed. The enjoyment of physical chastisement by the master of that school, not uncommon in schoolmasters in a day when opinion fostered rather than forbade corporal punishment of soldiers, sailors, scholars, and servants, came near smothering Crabbe's tendencies to knowledge. At twelve he was removed to a better

institution, where he achieved considerable attainments. Here he wrote much doggerel and some creditable verses. The aim of this second school was to qualify him for the medical profession, as it had been decided he should be bred as a surgeon. Accordingly he was, like Lawson Tait, bound apprentice to a country practitioner. From the time he left the school until he was apprenticed to a surgeon near Bury St. Edmunds he had still irregular warehouse training. The first master employed him as an errand boy and man of all work after the fashion of Marryat's "Japhet in Search of a Father." Three years later he was regularly bound to a surgeon at Woodbridge. During this period he published his first poem, which was on a quasi-professional topic, "Inebriety." In 1775, when his apprenticeship and his twentieth year were completed, he returned to Aldeburgh, hoping his father would be able to send him to London to complete his medical education. At this time he obtained the appointment of parish medical officer, but all his father could offer him was a place in his warehouse. The poet was therefore compelled to trust to his own resources. He succeeded in obtaining funds to study medicine for eight months in London, when he returned to Aldeburgh as an assistant to a Mr. Maskill as a surgeon and apothecary. Maskill left Aldeburgh soon after, and Crabbe was again consigned to his own resources. Except during the winter of 1778 and 1779, when the militia were quartered at the town, he did not have much success in practice. He later came to London to try his hand at literature. Here the success of the "Library," the profits of which were given to the author by the publisher, brought him fame. He was ordained in the Church of England in 1781. He was at first assistant curate



at Aldeburgh, and afterward held small clerical places in different parts of England. Crabbe never lost the high ethical ideals of the medical profession. Unlike many clergymen he never tolerated the quack, as witness the famous chapter on "Physic" in "The Borough:"

There was a time, when we beheld the Quack,

On public stage, the licensed trade attack;  
He made his labor'd speech with poor parade  
And then a laughing zany lent him aid;  
Smiling we pass'd him but we felt the while,  
Pity so much that soon we ceased to smile;  
Assured that fluent speech and flow'ry vest  
Disguised the troubles of a man distressed:  
But now our quacks are gam'sters and they play

With craft and skill to ruin and betray.  
With monstrous promise they delude the mind

And thrive on all that tortures human kind,  
Void of all honor, avaricious, rash,  
The daring tribe compound their boasting trash—

Tincture or syrup, lotion, drop, or pill,  
All tempt the sick to trust the lying bill;  
And twenty names of cobblers turn'd to squires

Aid the bold language of these blushless liars.

There are among them those who cannot read  
And yet they'll buy a patient and succeed;  
Will dare to promise dying sufferers aid,  
For who when dead can threaten or upbraid.  
With cruel avarice they recommend  
More draughts, more syrup to the journey's end.

"I feel it not;" "Then take it every hour,"  
"It makes me worse;" "Why then it shows its power."

"I fear to die;" "Let not your spirits sink,  
You're always safe while you believe and drink."

How strange to add, in this nefarious trade  
That men of parts are dupes by dunces made,  
That creatures nature meant should clean our streets

Have purchased lands and mansions, parks and seats;

Wretches with conscience so obtuse, they leave

Their untaught sons their parents to deceive;  
No thought of murder comes into their head;  
Nor one revengeful ghost to them appears  
To fill the soul with penitential fears.

Yet not the whole of this imposing train  
Their gardens, seats and carriages obtain;  
Chiefly indeed, they to the robbers fall  
Who are most fitted to disgrace them all;  
But there is hazard—patients must be bought,

Venders and puffers for the poison sought:  
And then in many a paper through the year,  
Must cures and cases, oaths and proofs appear;

Men snatched from graves as they were dropping in.

Their lungs coughed up, their bones pierced through their skin.

Their liver all one scirrhus and the frame  
Poisoned with ills which they dare not name.

Men who spent all upon physicians' fees,  
Who never slept nor had a moment's ease,  
Are now as roaches sound and all as brisk as bees.

Crabbe dealt a severe blow at the soothing-syrup fads, as prevalent in his

day is in ours. The practice of nurses in this particular was identical with that of today. Too many newspapers at present still urge the "soothing syrup," albeit the rise of a non-narcotic, non-secret nostrum has nearly killed the soothing syrup in maternal favor:

Who would not lend a sympathizing sigh  
To hear yon infant's pity-moving cry,  
That feeble sob unlike the new-born note  
Which came with vigor from the op'ning throat,

When air and light first rushed on lungs and eyes

And there was light and spirit in the cries;  
Now an aborted faint attempt to weep  
Is all we hear; sensation is asleep.

The boy was healthy and at first expressed  
His feelings loudly when he failed to rest.  
When crammed with food and tightened every limb

To cry aloud was what pertain'd to him.  
Then the good nurse (who, had she borne a brain,

Had sought the cause that made her babe complain)

Has all her effort, loving soul applied  
To set the cry, and not the cause, aside;  
She gave her powerful sweet without remorse,

The sleeping cordial—she had tried its force.  
Repeating oft; the infant freed from pain

Rejected food but took the breast again,  
Sinking to sleep, while she her joy expres'd

That her dear charge could sweetly take his rest.

Soon she may spare her cordial; not a doubt  
Remains, but quickly he will rest without.

—*Medicine, December, 1905.*

## CLIMATE AND TUBERCULOSIS.

The *Seattle Post-Intelligencer*, in a recent issue printed the following among its editorials:

"The medical profession has about concluded that there is no climate which can be considered ideal for the treatment of tuberculosis. Not only are many cases being cured in cold and cloudy places, both at sea level and in the mountains—places formerly considered the very worst for this disease—but the results in the lands of continual sunshine are not as good as was at one time so confidently expected. On the strength of new facts gathered in the last ten years a discussion is now going on which bids fair to revolutionize popular ideas also.

"The matter is of extreme importance, as it is the commonest thing for consumptives to leave home in search of

an ideal climate when they would have had far better chances of being cured at home. It is now stated that such cures at low levels and in places lacking in sunshine are more apt to be permanent, whereas relapses occur in those cured in high altitudes. Travel and residence in health resorts are expensive, and unless the invalid is well provided with funds he suffers for the very necessities of life, hastening his own death, even if he does not become a public charge on the community.

"These facts are causing a new movement in the way of antituberculosis associations in all parts of the United States for the local treatment of their own sick. They are also causing a great outcry against the great annual autumn migration to Southern California of tuberculous people in the last stages of the disease. They flock south to escape the winter weather, only to die within a few months.

"Dr. George H. Kress of Los Angeles has reported upon these conditions, and his article in the *Journal of the American Medical Association* contains many facts of vital interest to this part of the Pacific Coast also. He shows that Los Angeles has a higher death rate from consumption than any other place in the United States, as we would naturally expect. Indeed, the statistics seem to show a general tendency to increase of this disease in southern cities, the lowest rates being in Cleveland and Detroit. The death rates by months in Los Angeles show the results of the winter migration of hopeless cases, for the fewest deaths are in July, and there is a regular increase until March, when the rate decreases again.

"The most interesting part of the report relates to the nationalities of those who died. The mortality rate of the Italians of that city is far less than among those people in the rest of the country, while that of Scandinavians is far greater there than in the whole

United States. As a general rule, with some exceptions, it seems as though natives of sunny Southern Europe are improved by that climate, but those from gloomy Northern Europe are injured.

"This new discovery is opening the eyes of physicians to the fact that all men are not to be considered alike in regard to climate. In other words, a place which hurts one may benefit another, according to whether or not they are physically fitted for the climate. It has long been known that the man must be studied as well as his disease, but it is now realized that his very physical characteristics—his complexion, even—must be considered in advising change of climate."

#### A PHYSICIAN'S MEXICAN WELCOME.

The Cananea (Mexico) *Herald* of February 10th says:

"Dr. H. M. Dudley returned to Cananea last Tuesday after having committed matrimony. It is safe to say that both the popular doctor and his wife will remember the day that they arrived here.

"To begin with Dr. Dudley made sure that he would arrive unnoticed by keeping out of sight at Naco and thus avoiding recognition. However, his modesty was unrewarded, for the word came to Cananea hours before the train arrived. When the train came in the newly married ones hustled to a carriage and discreetly drew the blinds lest they be recognized. But these precautions worked the wrong way. The fact that the carriage was, so to speak, in disguise, only made it more conspicuous. All went well until Rompullo was reached. There Dr. Burrow spotted the carriage and stopped it to offer his felicitations. And then things began to happen. No sooner had the carriage got under way again than several of the police stopped it and informed Doctor Dudley and his wife that they were under arrest and then drove them to the Rompullo cárcel. With much expostulation the unhappy pair disembarked

and were escorted to the interior of the jail. It is said that Dr. Dudley made some remarks to his wife about the inevitable consequences of smuggling dutiable articles across the border, but this rumor has not been authenticated. However, his countenance wore a very troubled expression, which only cleared when Dr. Butzow dashed up to the rescue on his mettlesome steed. Explanations were in order and the now happy pair were released after having taken the oath of allegiance and having quaffed the national drink of Mexico.

"In the meantime, great industry was being exhibited in the vicinity of the carriage. Decorations in the shape of great streamers were being attached and when the culprits finally left the jail their vehicle was a sight to be seen. For a moment they balked, but being game they decided to take their medicine. They entered the coach of troubled matrimony and started on their journey. But the end was not yet. When they arrived at the Banco de Cananea Mr. "Tom" Ewing barred their progress, and their charioteer, knowing Mr. Ewing too well to ignore his presence, stopped. This was fatal. The concealed cohorts of welcomers swooped upon the coach even as the average woman dives at a bargain counter, and things began to happen again. All the rice in Mexico, according to some observers, was showered upon the unlucky pair, and all the old boots, shoes and slippers in Cananea were added to the storm. Finally Dr. Dudley took the matter into his own hands and the carriage started again for Capote. With a sigh of relief, the smelter was

passed. Nothing further happened along the way except for the cheers the decorated carriage evoked. At this stage of the game it is said that Dr. Dudley assured his wife that it was all over. But, he had missed his reckoning. On arrival at Capote the ubiquitous police were again on hand. This time, however, Mrs. Dudley was spared. Her husband was torn from her side and marched to the jail where he was heavily fined; the fine being about sixty drinks.

Almost exhausted with the strenuousness of their welcome the "Newly-weds" arrived at their home. The carriage was dismissed and came back through Cananea with streamers still flying, to be greeted with cheers again.

Again Dr. Dudley assured his trembling wife that all was over! And again he had another guess coming!

About ten o'clock the charivari commenced and it was the banner one of the year. All records for noise were broken. In fact the echoes lingered in the cañons until late the next morning and those who were out at dawn were puzzled to account for the unusual atmospheric disturbance until they remembered the Dudley charivari. Down in Cananea, five miles away, the row could be heard over the telephones so plainly that it sounded like the crack of doom. Dr. Dudley stood the racket very well, however, and responded to the occasion right nobly.

Taking it all in all, it is safe to say that Dr. and Mrs. Dudley will not forget for many years their welcome to Cananea.

## BOOK REVIEWS.

### THE ECLECTIC PRACTICE OF MEDICINE.

By Rolla L. Thomas, M.D., Professor of the Principles and Practice of Medicine in the Eclectic Medical Institute, Cincinnati, O., Ex-President of the National Eclectic Medical Association; Consulting Physician to the Seton Hospital. Illustrated with 2 lithographs in colors, 8 color prints and 57 figures

in black. 8 vols. 1043 pages. Price (cloth, \$6.00; sheep, \$7.00). The Sessler Brothers Company, Publishers, No. 100 Pine street, Cincinnati, Ohio.

The author of this handsome volume states that modern eclecticism's most characteristic and distinguishing tenet



is specific medication. There is a direct relation between drug action and disease expression, and having once learned this relation, or the affinity that a remedy has for a specific condition, we have learned it for all time. It were better for the doctor if he can forget that his patient has typhoid fever, pneumonia, dysentery, or whatever he may have, and study the conditions that are present.

There is a satisfaction in picking up a work which will tell you exactly what to do in a given condition. Take Osler, for instance, and he devotes most of the section devoted to treatment to telling you that he does not think this treatment or that treatment does any good, but Professor Scudder tells you just what to do and expresses no doubts. In the treatment of typhoid fever he says that hydrochloric acid is the ideal antiseptic, and prescribes hydrochloric acid 15 to 20 drops, simple syrup and aqua dest., each two ounces. One teaspoonful in water every one, two or three hours. In the cure of chronic ague he prescribes nitric acid 20 drops; aqua dest. and simple syrup each two ounces. A teaspoonful in water every three hours. In the treatment of acute rhinitis he says that it can usually be avoided by a single dose of 15 or 20 drops of gelsemium taken at bed time, or a few drops of the following: Camphor, turpentine, each two ounces; alcohol 1/2 ounce. Give of this 8 or 10 drops on sugar every three or four hours. If it be a weeping cold a half grain of powdered opium taken at bed time rarely fails to cut short the disease. Glancing through the work we see *belladonna*, *veratrum*, *pulsatilla*, and *colocynthis* very frequently mentioned. This work really presents a view of therapeutics that is novel to the young graduate of today, but at the same time we believe it would be very useful to every young physician to get this view. The broad practitioner is glad of an oppor-

tunity to see all sides of therapeutics, and then he can judge for himself what is best. We commend this work to the regular profession.

THE PRACTICE OF MEDICINE. A Text Book for Practitioners and Students. With Special Reference to Diagnosis and Treatment by James Tyson, M.D., Professor of Medicine in the University of Pennsylvania and Physician to the Hospital of the University, Fellowship to the Pennsylvania Hospital; Fellow of the College of Physicians of Philadelphia. Member of the Association of American Physicians, etc. Fourth Edition. Revised and Enlarged. With 340 Illustrations, including Colored Plates. Philadelphia: P. Blakiston's Sons & Co., 1012 Walnut Street, 1906.

The best compliment that can be paid a textbook is the demand which is created for it. The fact that Tyson's Practice has appeared in four editions in ten years is sufficient recommendation for this work.

This new edition has been brought to date in all branches, and several new features have been introduced.

The chapter on Diseases of the Heart is especially good, and that portion dealing with Diseases of the Blood is full and certain. Infectious fevers, including tuberculosis, have been treated exhaustively and with great care, and diseases of the nervous system have received special attention. Several new diagrams appear in the text.

The whole book is carefully written and shows the best ideas of a safe, conservative teacher. I take pleasure in recommending it to the medical profession.

MAN AND HIS LEGIONS. A Practical Exposition of the Causes, Symptoms and Treatment of Self Poisoning. By Albert Adams, A.M., M.D. (Harvard); F.R.M.S., Consulting Physician Denver National Hospital for Consumptives, the Mount Zion and the French Hospitals, San Francisco; President of the American Association Potyclinic; formerly Professor of Pathology and Director of the Medical Clinic, Corner Medical College, San Francisco. F. B. Frost & Co., Publishers, 1141 West Twenty-third Street, New York.

This little book, like "The Blues," by the same author, is one that shows origi-

## A Therapeutic Crutch



In feeble old age and in all cases of chronic weakness Colden's Liquid Beef Tonic, when administered in doses of two tablespoonsfuls ten minutes before each meal, acts as a therapeutic crutch. It supports and uplifts the enfeebled organism by increasing the activity of the nutritive processes.

Colden's Liquid Beef Tonic acts on the entire digestive tract. It sharpens the appetite and increases the quantity and quality of the gastric juice. Food is better digested, nutrition is improved, a feeling of well-being is produced, and the declining years of life are made more comfortable. Write for sample and literature. Sold by all druggists.

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inal thought. It brings before the physician certain symptoms and conditions and treats of them in a way which is somewhat new, and yet at the same time, rational.

The author is of the opinion that our attention has been called so much to germ life and the germ theory of disease that we have neglected somewhat other causes.

In this little book he takes up the idea of self-poisoning, and tries to show the effect of fatigue, fears, different nervous conditions and phenomena upon the economy. He also points out that many of these conditions have their seat in the intestinal canal.

"Gastro-intestinal poisoning, as I view it, is in the majority of instances not an acute but a chronic condition. Dis-

cretion in diet while very essential in treatment is by no means always radical. We must pay due regard to abdominal venous congestion by methods referred to elsewhere. Unless the latter condition is corrected by abdominal and respiratory exercises, the results of treatment can never be permanent. It is true that self-poisoning of intestinal origin may occur even in the absence of venous congestion, yet in my experience the latter is practically a constant condition."

It is a book that is well worth reading, and cannot help but stimulate thought.

THE WORLD'S ANATOMISTS. Concise Biographies of Anatomic Masters, from 300 B. C. to the present time, whose names have adorned the literature of the medical pro-

region. By G. W. H. Kemper, M.D., Professor of the History of Medicine in the Medical College of Indiana, Indianapolis, Ind. Revised and enlarged from the original serial publication in the *Medical Book News*. With eleven illustrations, nine of which are portraits. P. Blakiston's Son & Co., 1912 Walnut Street, Philadelphia, 1905.

We are very much surprised that an American book with this title has nothing in it about Corydon L. Ford, who filled the hearts of thousands of American students with an enthusiasm for this important branch. Oliver Wendell Holmes said it was worth a trip across the Atlantic Ocean to hear Corydon L. Ford deliver a lecture on anatomy. His work in the Long Island College Hospital and in the University of Michigan will live forever.

And there is Joseph Pancoast, who was a wonderful anatomist and a graphic teacher of anatomy. How could Dr. Kemper overlook such an eminent man?

Another man who should, we think, be in any list of the world's anatomists, is W. W. Keen. Had Dr. Kemper stepped into that little building where, three decades ago, Dr. Keen was lecturing to an audience of medical students that packed his amphitheatre there would not be this omission in this book. Besides Dr. Keen's work as a teacher of anatomy he has, during all his professional life, been a lover of anatomy and an original worker in that branch. We hope these three anatomists of world wide reputation will be found in the second edition of this charming book.

**DISEASES OF METABOLISM AND THE BLOOD. ANIMAL PARASITES. TOXICOLOGY.** Edited by Richard C. Cabot, M.D., Instructor in Clinical Medicine in the Medical School of Harvard University. An authorized translation from "*Die Deutsche Klinik*," under the general editorial supervision of Julius L. Salinger, M.D., with one colored plate and fifty-eight illustrations in the text. Cloth, \$6. New York and London: D. Appleton & Co., Inc.

This is the second volume of *Modern Clinical Medicine*. The first volume

of this series, *INFECTIOUS DISEASES*, was issued several months ago.

The work may be regarded as setting forth the most advanced teaching in medicine. It is an epitome of the latest researches in a field hitherto regarded as obscure and almost unexplored. The work is unexcelled in any language and should have a place in the library of every physician. The busy practitioner both in medical centers and in remote hamlets may here find his inspiration and guide. One of the distinguishing features of the work, which renders it especially valuable to the practitioner, is the very full discussion of treatment, embracing full diet-lists as well as all the modern aids, such as organotherapy, medical gymnastics, massage, hydrotherapy and electro-therapeutics, without subordinating actual drug treatment.

One whole section is devoted to the Animal Parasites of Man. Another to Important Poisons and Their Treatment. See editorial.

This is a delightful and valuable little work, and no library of medical history will be complete without it.

**CASE TEACHING IN MEDICINE. A Series of Graded Exercises in the Differential Diagnosis, Prognosis and Treatment of Actual Cases of Disease.** By Richard C. Cabot, A.B., M.D. (Harvard), Instructor in Medicine in the Harvard Medical School, and Physician to Out Patients at the Massachusetts General Hospital, Boston, U.S.A. D. C. Heath & Co., Publishers, 1906. 226 pages, with space for additional notes, \$1.50.

The distinguishing characteristic whereby medical teaching of the present time has supplemented that of ten, or twenty or more years ago, has been the manner in which laboratory and clinical instruction has supplemented didactic training.

The "laboratory method" in which each student is made to do and think for himself has not remained confined to technical colleges and medical institutions, for during recent years law has also been taught by the "case system," i. e., by the system in which the student



is made to acquire his knowledge of authorities by having presented to him for analysis and development, cases such as he would meet in active practice. Because the Harvard Law School was instrumental in introducing this method, it is sometimes spoken of as the Harvard Case System. We have often wondered why this abstract method of considering cases was not utilized in medicine also.

That it can be, is shown by Dr. Richard C. Cabot, of Harvard, who has been using the system most successfully for some years and who now presents it to the profession in a volume containing more than two hundred well devised case histories taken from his private and hospital practice.

Because this mode of instruction is so new in medicine and because we

deem it so valuable and worthy of trial, we quote at some length from the Introduction.

Cabot states that the advantages for the student, by this method are:

1. We can present a boundless wealth of material, unhampered by the narrowness of our clinical resources.

2. We can present it precisely as it is met with in practice, the important facts deceptively entangled with what is irrelevant and misleading. Then we can help the student disentangle the essentials.

3. We can test the pupil's ability to gather up and use the knowledge he has acquired from various sources.

This book should be of interest not only to instructors but to physicians generally. In ordering, the "physician edition" with answers should be asked for.

## THERAPEUTICAL HINTS.

Campho-Phenique is most highly recommended in the treatment of ulcers, boils and carbuncles. It not only destroys the bacterial growth but builds up the tissues as well. When it is once given a fair trial practically every physician adopts it. See advertisements in this magazine.

\* \* \*

Ferd C. Valentine, M. D., finds Sulpho-Lythin especially valuable for correcting the digestive phosphaturia that aggravates genito-urinary infections.

\* \* \*

### HAIR TONIC.

Quinine sulph. .... 20 grains  
Glycerin ..... 4 drams  
Sp. lavender ..... 2 drams  
Whisky, q. s. .... 16 ozs

\* \* \*

### HAIR OIL.

Castor oil ..... 1 pint  
Colonial sps ..... 1 pint  
Oil bergamot ..... 1 dram  
Oil lemon ..... 1 dram  
Red Saunders, q. s. color

The superiority of Syrup Trifolium Compound with Cascara must be apparent when its composition is noted. Each fluid ounce contains the active constituents of Red Clover Blossoms, 32 grains; Lappa, 16 grains; Berberis Aquifolium, 15 grains; Nanthoxylum, 4 grains; Silingia, 16 grains; Phytolacca Root, 16 grains; Cascara Amarga, 16 grains; Potassium Iodide, 8 grains, and Cascara Sagrada, 40 grains. The dose is from one to two teaspoonfuls, three times a day.

While it is particularly indicated in the treatment of secondary syphilis, with or without mercury, Syrup Trifolium Compound with Cascara commends itself as a general alterative. In skin diseases it evidently stimulates the action of the emunctories, adjusts the balance of waste and repair, and produces marked improvement. Many eruptive diseases are aggravated by constipation, induced by sedentary habits, and in such cases Syrup Trifolium Compound with Cascara P. D. & Co. may be regarded al-

most as a specific. While regulating the bowels and restoring natural peristalsis, it continues to exercise its alterative effect, which is enhanced by the elimination of waste products. In psoriasis and eczema it may be found effective when other measures produce indifferent results.

\* \* \*

J. E. Aker, M. D., says: "I had been accustomed to prescribe heroin alone, but about a year ago, my attention was called to a preparation of that drug—Glyco-Heroin (Smith). Upon giving it a good trial I found that it gave me better results than obtained when heroin alone was given, and much more quickly. Glyco-Heroin (Smith) has one distinct advantage over plain heroin in that it can be given for a long time without ill effects, and in the class of patients in question this is, indeed, a most important feature. During the past year and a half I have treated a number of cases and recurrent winter coughs with Glyco-Heroin (Smith) and have obtained uniformly good results.

\* \* \*

Dr. Solomon Solis Cohen, a distinguished Philadelphia physician and author, says that "the knowledge of the power of Collargol in septic and septicotoxic conditions should be made more general." He has seen two recoveries from malignant endocarditis and numerous recoveries from other grave infections by its energetic employment intravenously and per rectum.

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For SALE — A Morton-Winchester-Holby Static Machine with complete X-Ray equipment. Late style; good as new, at half cost. Phone. South 2709. Home 29120.

\* \* \*

P. Blackiston's Son & Co. announce that they have sold of Gould's Medical Dictionaries during 1905, 17,084, making a total of 108,257 copies of Gould's that have been sold.

Sander & Sons, whose Eucalyptol has deservedly gained such an excellent reputation with the medical profession, have been having a law suit in Melbourne, Australia, with a firm that has been imposing on the public by using a similar name. Sander & Sons instituted proceedings against the imitator and obtained a verdict by virtue of which the firm in question is perpetually restrained from doing so any more.

\* \* \*

Sulpho-Lythin is a true Hepatic stimulant; replaces calomel in all cases where that drug is indicated and is indispensable in the preparation of patients for operation. By using this valuable remedy the chance of anaesthetic and surgical shock are greatly lessened by restoring functional activity of the liver and excretory organs and counteracting acid toxanemia.

\* \* \*

#### ABBOTT'S SALINE LAXATIVE

It is universally admitted to be desirable to accomplish any necessary therapeutic indication with the smallest necessary quantity of medicine and the least possible interference with the functions of the body. Since we must help, let us give absolutely not a hair's breadth more assistance than is requisite, since further aid ruins self-dependence, both moral and physical. For this reason Abbott's Saline Laxative is superior to the crude salts and Saline waters, because when administered in this form the dose is but a small fraction of that required of the raw salts. Saline Laxative also has the unique distinction of being the only saline in the market which, when taken on rising, acts just after breakfast, *once only*, without a particle of irritation or griping, and then stops for the day. Other salines and especially the crude purgative waters will often continue acting at intervals all day long, to the intense discomfort of the victim. The same (efficient) dose of Abbott's Saline Laxative may be

continued, if necessary, for years, without needing to increase it.

It is obtainable either on prescription at all leading pharmacies or direct from the laboratories of The Abbott Alkaloidal Company, Chicago.

\* \* \*

Dr. J. T. Newman of New Orleans, La., in a paper on "The Selective Action of Sanmetto Upon the Genito-Urinary Apparatus," says: "I have used this remedy (Sanmetto) in all forms of cystitis and other affections of the urinary apparatus, but I desire more particularly to call attention to its value in chronic prostatitis, which occurs more especially among old men; and I can truly say, without exaggeration, that in my hands it has especially selective action upon the prostate. I am sure that any medical man, who will give Sanmetto an impartial trial, will become convinced of the truthfulness of this assertion."

\* \* \*

#### BEER DRINKING.

Recent statistics show that the consumption of beer in Germany during the year 1897-98 was 1,383,700,000 gallons; 1,192,000,000 in Great Britain; 180,000,000 in France, and about 60,000,000 in Russia. A better notion of the popularity of beer as a beverage is to be had from the estimates of consumption "per head" of the population. It is reckoned at 36 gallons in Belgium, 32 in Great Britain, 25 in Germany, 21 in Denmark, 12 in Switzerland, 10 in the United States, 9 1-2 in Austria-Hungary, 9 in Holland, 5 in France, 3 1-2 in Norway, 2 1-2 in Sweden and 1 in Russia.—*Medical Record*.

\* \* \*

#### BEST RESULTS THAN FROM ANY COMBINATION.

I must say that NEUROSINE has given better results and more universal satisfaction than any combination ever used by me. I have tried it in many nervous affections and in epilepsy of long standing. In some it is a specific in others a therapeutic agent of great value.—W. L. Gahagan, M. D., Coroner of Hamilton county, Chattanooga, Tenn.

Fats, according to Ebstein, should replace the carbohydrates of the diet since the latter, unlike the fats, tend to cause deposits of fat about the heart and thus impede its action. Ebstein expresses a preference for butter, but Bonner has shown conclusively that cod liver oil, owing to the ease with which it is hydrolysed by steapsin, produces quicker and more lasting results than butter, the volatile fatty acids of which tend to irritate the stomach when liberally used. Cod liver oil is best administered in its pancreatic or partly hydrolysed form known as hydroleine or hydrated oil.

\* \* \*

#### DR. OSLER AT MUKDEN.

Kuropatkin in retreat, a most dejected man,

He sat in contemplation on an empty vodka can,

And as the little yellow men their cordon closer drew,

He muttered low in Muscovite, "If Osler only knew!"

"That little fellow Nogi, though he's past three score and ten,

Is prancing like a three-year-old around my Russian men,

Is tying Tie Ling in a knot that breaks my line in two—

If Osler only knew of this, if Osler only knew!

"Then there's that old Oyama, who my stubborn center stormed,

He certainly is past the age he should be chloroformed;

Yet there he stands performing tricks that younger men should do—

If Osler only knew of this, if Osler only knew!

"Kuroki's getting on in life and surely should retire;

Then, what's he doing on my left directing of the fire,

And doing other boyish things an old man shouldn't do?—

If Osler only knew of this, if Osler only knew!

"That old man Nogi's worth about three hundred thousand boys,

But, oh, my military pride it certainly annoys

To be defeated by this superannuated crew,

Who'd be retired and fossilized if Osler only knew!"

—Wallace Irwin in the *Globe*.



## LAND ON YOUR FEET.

You take a cat up by the tail,  
 And whirl him round and round,  
 And hurl him out into the air,  
 Out into space profound:  
 He through the yielding atmosphere  
 Will many a whirl complete;  
 But when he strikes upon the ground  
 He'll land upon his feet.

Fate takes a man, just like a cat,  
 And, with more force than grace,  
 It whirls him wriggling round and  
 round,  
 And hurls him into space:  
 And those that fall upon the back,  
 Or land upon the head,  
 Fate lets them lie just where they fall—  
 They're just as good as dead.

But some there be that, like the cat,  
 Whirl round and round and round,  
 And go gyrating off through space,  
 Until they strike the ground:  
 But when at last the ground and they  
 Do really come to meet,  
 You'll always find them right side up—  
 They land upon their feet.

And such a man walks off erect,  
 Triumphant and elate,  
 And with a courage in his heart  
 He shakes his fist at fate:  
 Then fate with a benignant smile  
 Upon its face outspread,  
 Puts forth a soft, caressing hand  
 And pats him on the head.

And he's fate's darling from that day.  
 His triumph is complete!  
 Fate loves the man who whirls and  
 whirls,  
 But lands upon his feet.  
 That man, whate'er life ups and downs  
 Is never wholly spurned.  
 Whose perpendicularity  
 Is never overturned.

—Sam Walter Foss.

THE WAY TO SPONGE FEVER  
PATIENTS.

The following prize-winning description of how to sponge a patient is quoted from the *Hospital*. When about to commence to sponge a fever patient the exact temperature of the body must first be noted. For tepid sponging the water prepared should be from 80 to 90 degrees F. Remove all personal clothing from the patient and place blankets both under and over him. Place beside the bed all basins, sponges, and towels, or anything that may be required, as under no circumstances should a patient be left during an operation. Commence at the head and sponge downward, exposing only one limb at a time. When the whole body has been sponged the patient should be wrapped in a warm blanket and left undisturbed for an hour or even longer. The temperature may then be taken again to ascertain how much it has been reduced. The same precautions should be used in cold sponging as in tepid. It will, however, be found advisable to sponge each limb over with tepid water before applying the cold, as it will then cause less shock to the patient. It is wise to keep a tin bottle at the patient's feet during sponging, as with the feet warm there is less fear of chill, and in the case of a fever patient there is always more or less danger of collapse. When the temperature has been reduced the body must be gently dried and a flannel nightgown put on. After a cold sponge the temperature may fall from 1 to 6 degrees; the colder the water the sooner the reaction takes place. Ammonia, cologne water, or vinegar added to the water makes it more cooling by its rapid evaporation. Sponging can also be done by wringing towels out of cold water, dry enough not to drip, and placing them one after another from the neck downward. When the feet are reached, begin again at the head and renew each in succession, continuing as long as necessary.

# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## AN EARTHQUAKE SYMPOSIUM.

BEING A RECITAL OF THE EXPERIENCES OF SOME OF THE SOUTHERN CALIFORNIA  
PRACTITIONERS WHO WERE ATTENDING THE SEMI-CENTENNIAL MEETING  
OF THE STATE MEDICAL SOCIETY AT SAN FRANCISCO,  
ON APRIL 18TH. 1906.

BY E. W. FLEMING, LOS ANGELES.

If Lord Lytton could have lived a day and a night in San Francisco during the earthquake of April 18 he would have put more flame and color into his destruction of Pompeii, and less hysteria and rioting.

For generations before Columbus discovered the lands on the other side of the western ocean the scientists of Spain and Italy were accorded due reverence for their profound knowledge of the seemingly unknown. Then came the voyage of discovery and the old wisecrackers were without honor in any country.

A similar awakening is following the war of the elements in San Francisco. For generations men have written of devastating earthquakes much as they have of ghosts—they were the pliable creatures of a vivid imagination. But we who were in San Francisco during the earthquake and conflagration that followed it have been through the Dante's Inferno. We have seen the

ghosts—we were a part of it; and we are now asked to relate our experiences in the same spirit that the wraiths of the Inferno were ordered out on dress parade for the delectation of the old Italian poet and romancer.

My first sensation on the morning of the earthquake was a wild nightmare of the Welsh rarebit variety. Suddenly I became aware that I was standing in the middle of my room in the Palace, plunged into Stygian darkness and struggling with my pajamas amid a roar and rending beside which that of the cataract of Niagara is but the "lap, lap" of the waves on a summer inlet.

The great hostelry was writhing and swaying like the death struggles of a mighty boa. Plastering and wall decorations were piled in an indiscriminate heap on the floor. The air was oppressive. From without came the roar of a great city tossed about like a bauble by the giant forces of nature.

"This is no Welsh rarebit," I said

to myself as I groped for the door, "this is an earthquake and I am among the missing;" for the roar was as though the top floors of the Palace and the heavens above it were crashing right down on my head.

For a moment I stood stunned as the twisting and writhing increased and the roar without grew in intensity. Mechanically I stumbled about hunting for that door. The crash hadn't come yet and I moved with a kind of dumb animal instinct. It was not my first experience with an earthquake in San Francisco. I was born in Oakland and as a boy eight years of age, I went through the earthquake of 1868. Then we thought that was terrific; now I know it was only as the ripple on the surface of the bay to a storm at sea.

I still groped for the door. I had lost my bearings but I wanted to get into the doorway so that I would be safe until the walls themselves crumbled. Just as I reached it the building gave one last convulsive shudder and righted itself.

But I fled as from a falling wall. I was possessed by a dumb terror that no words can express, a nameless fear that one who has not at some time been the sport of the demons inside the earth will never understand. You can no more describe it than you can explain the sensation of burning to one who has never felt the fire.

In the street I mingled with as motley a brigade as ever graced a thoroughfare of a large city. Men were in pajamas—and less; women clad in night robes trod barefoot over jagged broken sidewalks. There were every hue and color of raiment meant never to be seen outside the boudoir.

The street was a perfect Babel of tongues; nameless terror was written on every face. The great steel buildings on Market street were all standing, but they were shorn of ornamentation. Nave and cornice lay on the street in a broken mass.

Fronts of the two and three-story brick and frame buildings had tumbled right out into the street. At places the debris had crashed through the sidewalk into cellars below.

Red tongues of flame lapped in and out among the ruins of these smaller buildings. A gong sounded and the people swayed back to the sidewalk as a fire engine, drawn by frightened plunging horses, rolled past.

The sight of that engine gave us a kind of weird reassurance; what at first seemed the end of all things might after all be only one of the great catastrophes that sadden the pages of the world's history.

I went back to my room, dressed, packed my grip and returned to the street. By this time half a dozen distinct fires were burning. Soldiers were patrolling the street.

In front of the Palace stood two women from Los Angeles. They were without escort. I spread my overcoat on the stone steps in front of an adjacent building and told them to sit there out of harm's way.

In less than two minutes those steps appeared to pitch right forward at me. The street gave a convulsive shudder and the groaning and writhing began afresh.

Like frightened animals we stampeded to the center of the street. The great buildings were writhing and swaying over our heads like trees in a storm. Again the nameless terror clutched at my heart. I stood with a strange fascination watching the interiors of buildings dumped out as from a mighty chute through front walls into the street.

I felt the ground dropping away beneath my feet. Vaguely I knew I was sinking into the earth. I closed my eyes to blot out the last. I felt my flesh a-quake. It was the twilight of the world.

But the roar and crashing ceased as suddenly as it had come. I opened



my eyes to see the Palace and the other big buildings still standing.

I followed the crowd out of the lane of high buildings to Union Square in front of the St. Francis hotel. There was a small open space where the danger of being crushed by falling walls was not so great.

In the streets we were brushed by ambulances and automobiles carrying the injured away to hospitals. The police and soldiers were assisting. Firemen were rushing engines and apparatus into the flame-lapped district.

Under the conditions the organization and energy displayed by the soldiers and the firemen were simply marvelous. Apparently the sense of discipline was the only one not deadened by the shock.

It was a desolate white-faced crowd that gathered in Union Square; but there were no tears, no hysteria; the great shock had made all equal. The hand of Fate was held suspended over the stricken populace; class distinctions were blotted out.

For the time gold was a thing not greatly to be desired. In the wrecked, devastated buildings was costly loot to be had for the taking, but the hand of the looter was palsied.

Death stalked through the streets and we knew not whither to flee. We strove lamely, pitifully, to assure each other that the worst was over. But every few minutes a convulsive shudder swept through the city—the orgie of the demons of the nether world was not yet ended. At each recurrent shake words of assurance would falter on white, drawn lips.

By noon the shaking had ceased. After that it was only the fire, and measured by the experiences we had received that morning, the greatest conflagration of the century seemed but a tame, commonplace affair.

During the afternoon wild rumors came of horror and desolation outside of San Francisco. Wild-eyed men told

each other that not a brick building was standing in all Los Angeles; that Chicago and Portland had been swept by tidal waves; that Long Island had been swallowed up by the sea.

All these rumors we received with credence. In the light of the happenings of the last twelve hours these disasters seemed trivial.

That night I spent in Golden Gate Park. Before morning it held tens of thousands of refugees. At noon Thursday I started with the other three members of our party to make our way to the ferry.

Then the conflagration was at its height. Whole blocks were swept away by the flames almost at a breath. Soldiers and sailors were dynamiting rows of houses, hoping to check the march of the fire fiend.

We picked our way through the burned district along Howard street to the water front. Blackened desolation was about us and crowds of motley refugees thronged our path.

The flames had licked up the whole street; it was like walking through the avenues of a blackened, forgotten city. Nothing had escaped and the very desolation of it crept into our hearts and drove out the sense of fear. Here the flames had swept with great rapidity. In some places the fire fiend had evidently locked people in buildings and burned them alive. The loss of life in that district will never be known.

On Howard street near Market lay the half burned bodies of two men. One had apparently been caught in the debris of a falling building; but the other lay full on the street. Half the body was burned to a crisp, the other part was hardly blackened by the flame.

We reached the ferry and the boat was waiting. I secured a place at the stern; as we pulled out into the bay I had my last view of the old San Francisco.

That panorama of flame and ruin is pictured indelibly on my brain.

In the foreground were the skeleton ruins of the great buildings on Market street. Far beyond, the flames were rushing on their triumphant course to Van Ness avenue and Nob Hill.

Dense columns of black smoke rose hundreds of feet in the air, swirling and turning like water spouts; through them and about them darted tongues of flame, and above it all burned the sun, red and angry. It might have been the demon marshalling the flames. The blue waters of the bay were tinged with the crimson of the flames and sky. This is the picture that is burned on the canvas of my memory.

As a boy I had played among those hills, and the city and I had grown to-

gether. I had rejoiced at the laying of the corner stones of many of these magnificent buildings. I was now a silent mourner at the funeral pyre.

The boat glided into the slip at Oakland Mole, and the Owl was waiting. Five hundred voices were asking for news from as many places. We were back again in the moving, throbbing world.

A conductor assured me that Los Angeles was safe. "Never touched it," he said; "you fellows are the only ones that caught it."

And with a great sigh of thankfulness I turned my face from the burned, blackened city to the future.

#### BY JOHN C. KING, BANNING.

As some of you may know, Mrs. King and I are familiar with earthquakes. Years ago a store in which we owned an interest was wrecked by an earthquake. One Christmas night the wreckage in our home cost us some hundreds of dollars. A year since we were chased out of bed in the same room, in the same hotel where we were caught napping on the morning of the 18th. We have passed through dozens of minor shocks, but this last one was a different breed. We were quite calm, but our judgment told us we were living in too high an altitude. We descended six stories with indecorous haste; that however, was because courtesy compelled us to make way for the Drs. Bullard, who occupied the floor above us. Later we chartered a one-horse express wagon and sought a more congenial climate. One of the impressive sights was Van Zwollenberg's legs dangling over the rear end of that wagon. I never realized a man could own so much legs. I regret to state the immaculate Dr. Van had apparently found no leisure for his morning ablutions. Not less imposing was Dr. Rose Bullard, perched on a high trunk, her naturally quiet dignity en-

hanced by the jarring over the cobblestones. The overwhelming effect of the calamity can be understood when I assure you that charming Dr. Frank D. remained approximately silent during the whole ride. Thursday morning certain of the State Board, together with a devoted band of applicants, assembled at Dr. Tait's residence on Post street. The work of the Board was rendered difficult by the announcement that the building was about to be dynamited. The well known esteem and affection of the applicants for Dr. Tait was beautifully manifested. Three trunks of the doctor's books were packed, a rope attached and two stalwart applicants harnessed to each. The doctor's parlor sofa was brought down, loaded with the necessities of life and other applicants attached thereto. Then began the procession, the applicants dragging trunks, sofa, etc., escorted by the examiners, and Dr. Tait's lovely lady. Five squares out Post street, we found an unoccupied corner, the lady was enthroned upon her elegant davenport, and the more serious duties of the Board resumed. To me, the most wonderful thing was the calm-

ness of the stricken, fleeing people, and their kindness to each other. The most terrible — childbirth on the sidewalk. Mrs. King and I can never forget the kind attention of the utter stranger who

housed and cared for us, nor the generosity of Dr. Tait, who offered us his team to search for our daughter in the ruins of Stanford at a time when he most needed it himself.

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BY W. EDWARD HIBBARD, PASADENA.

Five-ten a.m., Wednesday, April 18th, found me in bed in the eleventh story of the St. Francis hotel, San Francisco. I awoke at this time, began rubbing my eyes, looked at my watch and saw it was five-ten and turned over for another nap. In a very short space of time I heard such a rattling of doors and windows, flapping of pictures on the walls and falling of chandeliers that I immediately thought it was a number of individuals trying to gain entrance to my room and were shaking the door and pounding the walls to gain admission; then I felt the building sway backwards and forwards and I immediately decided what the trouble was; namely, an earthquake. I went to the window overlooking the park and saw the tall monument in the center of the park swaying backwards and forwards and walls and bricks of neighboring buildings falling to the ground. I stepped to the side window in my room from which I could look right down on the steel structure addition in the course of construction and saw the steel beams and the entire skeleton structure moving backwards and forwards and seemingly bob up and down. I heard a loud noise and again went to the window overlooking the park. The earth seemed to have a wavy appearance as though I was looking down upon the raging waters of the ocean—there was then an extremely loud hissing, singing noise together with a loud report. All was then over and quietude seemed to reign again.

I opened the door of my room and looked out into the hall which was dark and seemed to be filled with what I then took to be smoke. Immediately

closing the door, and taking mental notes with myself, my impression then was that we had not only suffered an earthquake but that the St. Francis was also afire. This I could not understand as it was supposed to be a fire-proof building. To say I was frightened is putting it mildly.

After a very short space of time I again looked into the hall. The atmosphere had somewhat cleared and I then discovered that what I had taken to be smoke was dust caused by the falling of ceilings and walls on the lower floors, the dust having come up the stairways and elevator shafts. Having two friends, Drs. Mattison and King, on the seventh story and realizing I would meet them, I made the mental resolution while getting rapidly into my clothing that I would complete my toilet thoroughly as soon as possible and get out of the building, looking as if I had taken an hour to dress in order that my two friends would not have a laugh at my expense.

I went out into the hall and found the elevator was not running. A number of hysterical women were in the hallway, attired décolleté and otherwise—men equally scantily dressed and excited. I myself tried to be brave and encourage the women and men, lit a cigar and walked down stairs. In passing along the office floor I heard one gentleman remark to another, "See all the gold on the floor, do not step on it." We passed out the front entrance over into the park. My attention was attracted by a man scantily attired who was shouting for help from one of the windows of a small building at the south side of the park. I readily saw that this was one



of the older buildings—the adjoining building whose side walls were of brick, had collapsed and falling on the roof of this three story house, the upper floors of which were used for roomers. We immediately organized for the assistance of the occupants, the hallway and stairs being literally choked with bricks, plaster, laths and debris. After this I returned to the hotel and found my two friends, Drs. Mattison and King, in their respective rooms. Our thought was then that perhaps our assistance might be needed in rendering help to the injured, which we soon found was not needed as the San Francisco physicians responded so nobly and were fully able to care for all.

After learning this our next thought was to obtain breakfast. At this time fire was breaking out at a number of different points. We were blockaded in front of the United States Mint and saw wooden structures wrapped in flames with the firemen heroically fighting it. We found a cheap restaurant, I think called the "California Restaurant." Drs. Mattison, King and myself went and took chairs at one of the tables. We soon found it would be impossible to obtain food unless we helped ourselves, which we quickly proceeded to do, and in this way secured a fairly good breakfast. The proprietor was very much excited and people began crowding in, and before we had finished so great was the rush that they were compelled to close and bar the doors.

We went back to our hotel and in the park opposite the St. Francis met Dr. Kress, Dr. Frank and Dr. Rose Bullard and Dr. and Mrs. King of Banning. We also met Mrs. Linnard, wife of the proprietor of our Hotel Maryland, to whom Dr. Mattison had very courteously offered his protection. Later Dr. Mattison's uncle, a prominent business man of San Francisco, appeared and helped us decide what we had been debating among ourselves; namely, what was the best move for us to make. He sug-

gested inasmuch as he had come over from Oakland in a launch, that we detour the fire which was rapidly spreading along the water front. This we proceeded to do immediately. Dr. Bullard and wife, also Dr. King and wife of Banning, decided to go out to the Golden Gate Park. Bidding Dr. Kress, Dr. Mattison, Mrs. Linnard, Dr. King and myself to accompany him, Mr. T. F. Speddy, Dr. Mattison's uncle, then led us around the fire to the launch, which we reached after a long jaunt. We were compelled to stop every few minutes to allow Dr. Mattison to regain his breath, and when we finally reached the launch Dr. Mattison was as red as a lobster, puffing like a winded mare and bathed in perspiration. Dr. King very kindly paid for five in the launch, leaving Dr. Kress and myself to dig up or remain in Frisco. However, we managed to raise enough money to satisfy the owner of the launch and finally started for Oakland.

We found Oakland had also suffered very severely. We met Dr. Visscher on the Oakland pier who journeyed with us to Oakland. We found the hotel at Oakland crowded and without any vacant room for the night and we also learned we had arrived too late for lunch. We immediately started out upon a foraging expedition and after considerable trouble succeeded in getting a fairly good lunch, after which we went to the Southern Pacific ticket office and Dr. King and myself found we could get the Owl out that night. Dr. Mattison having gone over to Alameda to spend the night with his uncle's family, Dr. King and myself journeyed home that night, reaching Pasadena about 12:30 Thursday.

Before we left the St. Francis the chief clerk informed us that everything south and east was wiped out and Los Angeles razed to the ground. I returned again to Frisco Thursday night and secured a pass from our Governor and Gen. Funston, also a police

badge, which enabled me to freely penetrate any portion of the then burning city. As I walked up Market street tears came to my eyes—dear old 'Frisco, in forty-eight hours had undergone such a marvelous and indescribable change. The majestic Call building was still standing but charred and warped, ruin staring me in the face at every step. I found the sheriff of San Francisco very easy to get at, he was in the window of what had formerly been a corner grocery; he seemed not at all careworn but cheerful in the extreme. The four newspapers that had once occupied sky-scrapers in Newspaper Square were now printing their issues in Oakland. I went over to the Crocker-Woolworth National Bank, being acquainted with one of the officials in charge, went inside the building and learned that all the vaults and safes were in excellent order. I then went on to the St. Francis hotel and found the splendid steel structure still standing but charred beyond description. I journeyed out to Golden Gate Park where I saw ruin, ruin, ruin, and destruction on every hand. They had already established feeding stations, and lines from seven to ten blocks long were formed waiting for their evening allowance. The system inaugurated and maintained at this early period was astonishing to me. I found the temporary hospital equipment at the park and other places excellent, and that all was then being done that human skill and energy at that time could do. Making a careful tour of the park, I noticed many amusing but at the same time sad incidents. A gentleman and an orderly in an automobile were collecting overcoats to cover the babies in the parks. In a short space of time the auto was heaped and overflowing, not only with overcoats but undercoats and vests of pedestrians who had gladly sacrificed them to protect the babies. This was late in the afternoon, the fog was rolling in and there was every in-

dication of a cold night. While in the park I saw one of our multi-millionaires digging post holes at the point of the bayonet, and should I mention his name many readers would recognize him. The millionaire, professor, and the laborer were living in the park side by side, many sheltered by tents, others by wagons, others by trunks piled up with boards placed over them. In fact, every imaginable form of shelter was improvised to afford temporary protection against the elements. I saw a wealthy automobile manufacturer arrive in town with his automobile who had come up from Los Angeles. He was immediately pressed into service, but after riding five hundred miles or more, he simply could not drive any further, but gladly surrendered his auto to the service and said he would direct anyone in driving it, and before you could say Jack Robinson the auto was carrying dynamite and provisions.

As I passed through the streets next morning I saw professors, doctors, lawyers, scientific men of every class, together with millionaires, cooking their coffee and boiling their eggs. By the roadside, madam and her daughters likewise were seen cooking their breakfast. In fact, in any of the streets cooking their meals could be seen girls who had been educated at Vassar, Berkeley, Stanford and Bryn Mawr. I saw men in line that morning with rejected fish and tomato cans in their hands waiting their turn for coffee and the morning allowance, both professors and business men whom I had known two days before turn up their noses at anything short of Tate's, St. Francis, Palace, or some other well-known hotel or restaurant. As I passed down the street I saw a number of well-known men pitching brick and clearing the streets of debris at the point of the bayonet who would have scoffed at the very thought of such work a day before.

However, amidst all this chaos there

was nothing but cheerfulness and encouragement and a New England Yankee determination stamped on the face and in the minds of all, to set about the building of San Francisco anew—a determination to have a finer San Francisco than the San Francisco of old, in fact a fast and fixed purpose to build

such a city that would not only be the pride of the Pacific Coast, the gateway to the West, but the pride of this entire country, to equal, if not excel, any city in the world. Can there ever be a higher tribute paid to American pluck, determination, energy and perseverance?

#### BY FRANK D. BULLARD, LOS ANGELES.

My personal experiences at San Francisco seem most common-place. Places but a few blocks apart underwent great differences in severity of shock, and it so happened that the lives of myself and wife were spared because we were in one of the islands of least disturbance. Indeed we thought, until coming down from the sixth story and going out on the streets, that no great damage had been done. The moving to the hills, the forced march to Fort Mason, the escape from the city to Alameda at 1:30 Friday morning were but personal affairs. The awful grandeur of the fire, the cheerfulness and resignation of those who had lost their all, the reduction of all—the wealthy, the poor, the native, the stranger, the white man, the Chinaman, to the same primitive level—was one of the things that most impressed me.

The inter-dependence of man, the one upon the other, the uselessness of un-

organized effort, the necessity of obedience and the magnificence of intelligent organized relief work and the generous response of a nation are facts that stand out in prominence.

In it all there is a Californiaesque air of greatness. An expressman driving over the immense burned area and surveying the ruins, with much pride exclaimed, "Well, we have got Chicago skinned to death." I heard one doctor greeting another with the remark, "Well, has your house gone?" "Yes, I've lost all." Then, turning to view the awful scene, he exclaimed, "Isn't that a grand sight!" As we retreated to Fort Mason, a few blocks from the fire, we saw a man sitting on a porch watching the flames and fiddling like Nero at Rome.

We went from place to place, seeing if people and friends were hurt, but fortunately none of our acquaintances were injured at all.

#### BY H. G. BRAINERD, LOS ANGELES.

I reached the St. Francis Hotel about two thirty a.m. of April 18th, and at twelve minutes after five, I found it very difficult to stay in the bed which I was occupying. When first awakened I thought I was having a nightmare, but in a few seconds realized it was the "real thing." So near as I can tell the shock lasted between a minute and a half and two minutes, increasing in severity for something like a minute, and then with a very slight lull it recommenced, but apparently not

quite so severe as in the first part of the shock. At the last it seemed to diminish in violence during the last dozen or so oscillations. During the shock it did not seem possible to me that anything constructed by human hands could withstand its violence.

I was sleeping so soundly that I did not hear the preliminary rumble which awakened some people with whom I afterward talked, but the creaking and groaning of the frame work, the crashing of plaster, the crackling of mortar



and glass and other breakable material was accompanied by a terrifying roaring, rushing sound such as I cannot well describe, but can never forget; it seemed that the last day had come, every instant expecting a crash and roar that would end all. After the shock subsided I was astonished to find upon raising my curtain that the brick buildings in the adjacent square were apparently unharmed, and I concluded that I must have been more frightened than the occasion warranted, so went back to bed. At half-past five some one pounded vigorously on my door and inquired if I were all right, and advising that I better get up and dress and get out, and this invitation I promptly accepted—dressed and went down on the street, noticing that the doors of the room swung freely, that the floors seemed plumb, and that there was a great deal more damage to the plaster and glass on the second and third floors than on those higher up, due as it seemed to me to the hinge-like motion of the tall building upon the massive first floor. In the street in every direction where there were tall buildings there was a large amount of debris on the sidewalks, and often times extending across the street, which had come from the falling of cornice and ornaments, but no buildings in sight that were entirely collapsed. A building just above the St. Francis, eight or nine stories in height, leaned dangerously out into the street, and the same condition existed in numerous places which I noticed.

By 6 o'clock the smoke of various fires could be seen in a semicircle from the St. Francis from the southwest to the northeast. As we looked down Powell street beyond Market flames could be seen bursting from tall buildings.

After getting a light breakfast in the St. Francis I packed up my belongings and started with Dr. and Mrs. Pahl in an attempt to reach the Market street

ferry, as we could see that the ferry boats were still running. In the meantime we had learned from a member of the fire department that the city was on fire in forty different places, and that the water mains were broken and the fire department was powerless to cope with the flames. We went up Powell street to Broadway, then Broadway toward the water front, but nearing the water front the flames had already come so close to Broadway that we were obliged to make a detour still further to the north and we reached the water front near the sea wall. From the top of the hill at California street we had a good view of the lower part of the city, which seemed to me to be on fire in a score of places on both sides of Market street and extending to the west as far as Ninth and Tenth streets. The wind then was carrying it steadily up the hill, and it did not seem to me that any human power could prevent the destruction of the city.

It was a terrible and impressive sight to see the flames burst from all the windows of the massive buildings and then to see them come through the roof, and a few minutes later the roof falling in with a resounding crash that could be heard for many blocks away, and a shower of sparks and embers thrown into the air spreading destruction far and wide.

By 10 o'clock the United States troops—cavalry and foot—had established a picket around the district north of Market street just as far as I could observe, and were keeping the people well in hand. Along by the docks there were immense fissures in the earth, in some places portions of the street for hundreds of feet had dropped from three to six feet leaving great crevices on either side.

It was refreshing as we came along the water front to see scores of lines of hose throwing salt water on the burning cars and buildings, thus preventing the docks themselves from taking fire.

The Oakland ferry continued to run at regular intervals during the day carrying no passengers from Oakland to San Francisco but being crowded to the very limit with those seeking refuge on the other side.

By 11 o'clock the booming of dynamite and other explosives was frequently heard, and between 2 and 3 p.m. it was almost continuous in the vain efforts of the firemen and militia to check the progress of the flames by blowing up buildings that were in its path. On the east side of the bay comparatively little damage seemed to have been done, while a captain of a small steamer, whom I met on the water front, said he experienced the earthquake some thirty

miles out to sea, and that the motion was of the peculiar oscillation type such as experienced on land.

There were rumors that the whole coast from Seattle to San Diego had suffered as severely as San Francisco, and it was not until 9 o'clock that night when we reached Tracy on our homeward trip that we learned that no serious mischief had been done to Los Angeles, relieving us all from terrible suspense.

While nothing would tempt me knowingly to incur such danger and such dreadful scenes as followed the earthquake, it was an experience which I deem a most valuable one.

#### BY C. VAN ZWALENBURG, RIVERSIDE.

Occupying a room at the Grand Hotel, (a frame building) where I could not see the street, my first impression was that of a moderately severe shock, but no idea of serious damage. I kept my bed until all was quiet and dressed with comparative leisure. I did not begin to realize the situation until I had descended to the street and saw the debris of brick in the street and the universal wreckage of windows. Walked around the corner two blocks and saw two men rescued from a collapsed three-story lodging house. Heard another calling for help. Rendered what assistance I could, which I am sorry to say was but little. The fires starting in six different places within four blocks in each direction from where I was, at once struck me as the most appalling part of the disaster. My impression of the magnitude of it, however, has been constantly increasing ever since it occurred. It took a long time for its far-reaching effects to filter into my consciousness.

One impression was the stoicism with which everyone took the situation. During the 24 hours I spent on the

scene, I saw no tears on the face of anyone. Every one seemed so thankful to be alive that no horror or bereavement seemed to penetrate to the point of tears.

I was struck by the evidence of our dependence upon modern conveniences for our comforts and happiness, and at the same time the truth of the expression, "Our wants are many; our needs are few," came home to me.

To see an immense population of a great luxurious city deprived in a twinkling of elevators, street cars, electric lights, gas, telephone, telegraph, newspapers, water supply, restaurants, banks—to see all business come to a standstill without a moment's notice; to see fortunes wiped out and people of all classes in an instant brought to the same level, all intent upon saving themselves, whether anything else was saved or not—all impressed me with the littleness of man—the few absolute needs for his existence and the wonderful diversity and effect of the conveniences he has built up about him.

I offered my professional services but they seemed not to be needed. Physicians and nurses were sufficient

for immediate needs and I early decided that I had best absent myself from the congested city as soon as possible.

BY P. C. H. PAHL, LOS ANGELES.

The morning was glorious, the sun so bright, the grass so green, the flowers so fragrant, and San Francisco never seemed so beautiful as it appeared on Tuesday, the opening day of the State Medical meeting.

In going to our room on the ninth floor of the St. Francis, we congratulated ourselves upon being so well located in a beautiful fire-proof hotel. I hope that I may never again experience the sensation with which we were awakened at 5:12 o'clock the following morning. We were instantly aware that we were in the midst of a tremendous earthquake and the suspense of the moments which seemed like hours before the vibrations ceased, was terrifying in the extreme; the building swayed to and fro, and strong beams groaned and creaked, the tiling of the elevator shafts fell with a noise as of tons of breaking glass and huge steel beams from the adjoining wing, under construction, crashed ten stories to the ground. Within two hours of the first great shock, I distinctly counted fifteen distinct tremors. Immediately after the shock we heard the fire companies clanging down the street and, looking toward the ferry, saw the smoke of burning buildings which, in the course of several hours, increased voluminously. In our room not a piece of plaster fell nor was an article of furniture perceptibly disturbed so we were not aware that we were in the presence of so terrible a calamity. We performed our toilets leisurely and, without packing our luggage, walked down the marble stairs to the lobby where, to our surprise, we found most of the guests of the hotel huddled in terror with their hastily packed baggage ready to flee from the stricken city at

the first opportunity. We were informed that the city had been seriously shaken by the earthquake and was in imminent danger of being swept by fire; and even as we stood there tremor after tremor shook the building.

Anxious to see how extensive the fire was and if it were possible to reach the ferry, we started out in company with Dr. H. G. Brainerd, of Los Angeles, making a wide detour to Broadway, thence through the Barbara Coast to the water front, which the fire was rapidly traversing; everything about there seemed doomed to total destruction. In every direction terror stricken people with white faces, and hands filled with personal household belongings, were fleeing before the advancing flames. The ground, in many places, showed the mighty convulsions through which the city had passed; in places the streets were sunken or upheaved many feet, the water mains were broken and the car rails twisted like bits of wire.

We were invited aboard the freight steamer "Newport" which was ready to pull out into the stream at a moment's notice. Through the courtesy of the steward we obtained a much appreciated ship's breakfast. The faithful work of the different steamships in port, however, checked the fire and a large portion of the water front was temporarily saved.

We left Dr. Brainerd en route to the Oakland ferry, while we made our way back to the St. Francis. While passing through Chinatown, we met a large number of Los Angeles medicos, some with their suit cases and some without, all making their way to the ferry.

By three o'clock in the afternoon the Palace hotel burned and as the fire was still gaining ground we realized that



we were in great danger. Directing Mrs. Pahl to pack up our belongings, I made my way back to the water front to the Pacific S. S. docks where I obtained permission to go on board the S. S. State of California. Returning to the hotel I hustled my wife and our belongings into a carriage, for which I paid ten dollars, and started for the wharf, but, alas, when we came to Chinatown we found it on fire and, unable to proceed, we returned to the hotel, where the management was making the guests as comfortable as possible. As night approached provisions became scarce and, through the influence of a porter, we obtained from the servants' hall three slices of bread, two apples and coffee, after which, in company with many others we hid ourselves fourteen stories to the roof, remaining there until 1 o'clock a.m. when we witnessed probably the greatest pyrotechnic display that man ever beheld.

hundreds of acres, including Chinatown, hundreds of acres including Chinatown, the water front and everything south of Market as far as 20th street. We saw many of San Francisco's most beautiful buildings catch fire and burn entirely to the ground. The wind was blowing a gale and the air was filled with sparks and cinders. Finally when the building across the street from us, spontaneously caught fire, we decided that the hour to move on was at hand. Taking the spread, blanket and pillows from our bed and making a convenient roll for carrying, we moved our belongings out of the hotel into Union Square. The fire soon became so threatening that we again decided to move on, and it certainly was a sight, new to me, to see my wife with a bundle of blankets on her back and carrying a large suit case, trudging down the street while I dragged our trunk by a towel tied in the handle (by the way the noise peculiar to a trunk being dragged over the uneven

sidewalk is one I shall never forget). We went west on Post street for several blocks out of the immediate reach of the flames and Mrs. Pahl stood guard over the baggage while I went south on Market street to the district which had been burned during the morning to see if it were possible for us to go there in order to get out of the path of the flames. I was gratified to find that people were already going into the burned district for safety. Procuring, with some difficulty, an ordinary top buggy from a livery man who was moving his buggies into the burned district to escape the fire which was coming down Market street from the City Hall, I pulled this vehicle to the place where my wife was with the luggage; this we then hurriedly took to the corner of 6th and Mission streets, where we spent the rest of the night.

The wind was blowing about eighty miles an hour, the entire district was still more or less on fire, the air was full of smoke, gas and cinders and it was a funny old refuge we made on a bit of wind-swept sidewalk, out of our trunk, suit case and blankets; it was as good as anybody's, however. The portion of Market street we so recently crossed, soon broke into the most wonderful fire: large six-story hotels would crumble to ashes in thirty minutes. We saw the James Flood building, Praeger's Department Store, in fact, all of the buildings on the north side of Market street between the city hall and the Chronicle building, devoured by the flames.

Martial law was declared early Wednesday morning, and the soldiers were most efficient in maintaining order and supplying the people with food and water. Such a motley throng as filed down 6th street dragging their trunks over the rough cobble stones, bricks and fallen trolley wires; men and women, some on foot, some in vehicles, some crying, some singing.

At 5 o'clock in the morning in con-

junction with three other parties, we succeeded in taking our baggage down Folsom street to the water front and thence to the Broadway wharf. The entire distance traversed was through the fire-swept district. We had no difficulty in getting on board the "State of California" where we spent Thursday and Friday nights in great comfort. On Saturday morning it was announced that the boat would sail for Los Angeles at one in the afternoon, and all the remaining water front having been burned to the ground the night before, there was nothing to prevent us from taking an extended trip through the ruined city. We did this going up Broadway; wending our way to the Fairmount hotel, we retraced our steps of Tuesday morning and, with the beautiful views of Tuesday still in our minds, it was certainly hard to realize that this was Nob Hill with practically only the walls of the Fairmount hotel and the Flood mansion standing—everything else absolutely in ruins.

The Sequoia hotel, where we spent

our first night, was simply a heap of scrap, the St. Francis gutted entirely. We saw only one window on the Geary street side and in that the glass was badly cracked. As we passed down Market street, on our return to the steamer, the people were beginning to come back into San Francisco with supplies and food.

During our different excursions we saw only three dead bodies and comparatively few injured people. I dressed one case of empyema and prescribed for several fever cases. I thought the behavior of the people was something marvelous. While during the first days I saw many intoxicated people, I did not see one fight or any disorderly conduct. The authorities are to be congratulated for the efficient manner in which the whole affair was controlled.

Saturday at 2 o'clock our steamer sailed for Los Angeles where we arrived safely at 8 o'clock Sunday evening.

#### BY C. D. BALL, SANTA ANA.

The first shocks in the early morning of the 18th did not deeply interest me, for the enormity of the disaster had not become apparent. A very fat old gentleman, bare-footed, scantily clad in a blanket, was the first centre of attraction in my neighborhood. But the more serious side was quickly observed.

As the thousands of people poured into the streets the debris of the quake was everywhere encountered. Broken glass, bricks and stones from shattered walls, chimneys and cornices literally covered the pavement. Had the quake occurred during the busy hours of the day or evening, thousands would have been killed.

As the numerous fires broke out south of Market street and it became generally known that there was no

water to fight the conflagration, anxiety became general. This was increased when outside communications were cut off. The sun was obscured by the dense smoke and this gave the surroundings a lurid effect. During the morning an occasional tremble would send the crowd scurrying to points of safety. The writer two or three times was quite undignified in his haste.

It was an awful day, but as the sun went down it seemed as though the fire was yielding and there was more of a sense of security. It was thought, too, that the wild reports of loss of life were greatly magnified.

But the night will never be forgotten. In the early part of the evening we visited the great squares of the city, where the thousands who were without shelter were located. Nothing

could have been more pathetic. A family here, a single person there, a mother perhaps with a child or two huddled about her. Many without any covering whatever. One little boy without blankets, sleeping soundly with his roller skates hugged to his breast.

Then we climbed to the roof of a high building, looked down upon the burning hell, mile on mile of fire and smoke—the grandest and most terrible picture living man ever viewed, worse than Dante's conception of Inferno.

And now it was clear the fire was again making great headway and block after block was falling. At 3 a. m. of the 19th we joined the great crowd of homeless, our hotel having gone up in smoke.

Something had to be done—was it to be Golden Gate Park or the Oakland ferry? At a venture I started for Oakland and after a hard tramp of four miles around a sea of fire, reached the ferry and the fated city was left behind.

#### BY FITCH C. E. MATTISON. PASADENA.

At the time of the earthquake, I was in bed in room No. 728, Hotel St. Francis. I was awakened by a very violent shaking, and remained in bed until it was over. I had a very good view from my bed of the new steel addition going up on the north side of the St. Francis. After the shake was over I went to the window and could see a good deal of evidence of the damage done by the shake.

A knock came at my door just then. I opened it and Dr. Charles Lee King of Pasadena was there in a very undress uniform and wanted to know if it would not be best for us to get out immediately. We found a good many ladies in the hall, very much excited; we tried to quiet them, and I told them that I was going back to bed, as I thought the trouble was all over.

I went back to bed, but had no more than gotten in bed when the second shake came. I jumped out of bed and looked at the buildings out of my window and Dr. King came to the door again and suggested that we get out as he thought it was dangerous to remain in the building. We again went in the hall and tried to quiet some of the guests who were rushing down stairs panic stricken, and advised them to return to their rooms and get some clothing on, and I told them that I was going to get a bath and shave before I

went down stairs, as I thought we had ample time to get out, as the building was certainly a safe one to be in, and if we went down I would rather be on top of the heap than underneath. In the meantime I had turned the water on in my tub, had a plunge, shaved and dressed.

Just then Dr. Hibbard came to my door and said he had had been down stairs and there was quite a little destruction of buildings in the immediate neighborhood, and he thought we had better get out. The manager of the hotel had sent bell boys around just before that time advising the guests to get out. We went down stairs and were surprised at the evidence of damage done by the earthquake.

Several of us took a walk down in front of the Mint to see the extent of the fire. The fire was practically one-half to three-quarters of a mile long and was raging furiously at this time. There was also a fire on Market street, south of the Palace hotel. There seemed to be several fires on the north and towards the Ferry.

After watching the fire for a few moments and looking around, we returned and tried to get something to eat at the St. Francis, and were told they were going to serve coffee as none of the help had arrived. Dr. Hibbard, Dr. King and myself went down to the



California restaurant, near Tate's, to get something to eat. The building in which Tate's restaurant was, was very badly damaged, and the place was closed. We then proceeded to the Y. M. C. A. building, but it was so badly damaged that we were not permitted to enter. After discussing the possibilities of further sessions, we decided it would be best to see what we could do to help the San Francisco men out of their troubles.

By this time the fire was raging furiously. We returned to the St. Francis, packed our suit cases, and were intending to find some means of getting our party, which included several ladies, out of the city on the Oakland side, and while endeavoring to find some means to do it, an uncle and cousin of mine from Alameda found me in the hotel and told us of the destruction in Alameda and Oakland. They had come over in a gasoline launch and advised us to get out immediately and leave our baggage.

We proceeded through the burned district and found it necessary to go through Chinatown to get around the fire, and in doing so skirted the north end of it, and that took us down to about Pier 20 or 21, Pacific Coast Steamship Company, where we found the launch and went to Oakland.

Drs. Hibbard, Kress and King remained in Oakland to take the Owl down that evening. I went to Alameda and found it impossible to get back to San Francisco, but had a view of the fire, which I think was one of the grandest spectacles that a person could witness; it was horribly grand.

There was very little sleep in Alameda that night for I think most of the population watched the fire and wondered what we could do to help the people in San Francisco. We got up early and tried to go over to San Francisco but found that the boats were refusing to take the passengers. We

got a launch and a man agreed to land us, which he did at North Beach. I then tried to locate some of the San Francisco doctors to see what I could do in a professional capacity to help them out. I was told that they were moving the patients out of the hospital to the park and some on the short line, towards the cemetery. It was impossible to get a conveyance and the police and soldiers were advising the people to get out of town. The sights and scenes of distress and misery, the buildings and the panic stricken people was something that one does not want to witness but once in a lifetime.

The spirit shown by the people was one to be admired, as everybody was helping everybody else. Men, women and children were proceeding to the ferries in all manner of vehicles. There were garbage wagons containing as many as eight or ten ladies, beautifully gowned, but very much disabled. The people were carrying the baggage and tried to drag trunks along, they were carrying bird cages, pet dogs and cats. The endless stream of the fleeing population of San Francisco around to the north shore and ferries struck one as being the most distressing thing one could witness.

The exaggerated reports of the number of dead and in many instances of people almost refusing to leave their houses and property when they seemed to be almost involved in the flames was simply appalling at this time, while the fire was rapidly spreading, and men were dynamiting buildings to try and prevent the spread of the flames.

After returning to the ferry by going around to the south and attempting to go up Market street, I returned to Oakland and tried to find some of our party.

I left Oakland Friday evening for Pasadena, feeling rather tired out and in need of a new supply of glad rags, etc.

## BY W. W. BECKETT, LOS ANGELES.

The first news concerning the earthquake was given to us before leaving Tracy. We did not feel the earthquake on the moving train, so could hardly believe the terrible account that was brought to us of the San Francisco catastrophe.

We first saw evidences of the earthquake at Tracy where the water tank and chimney of the station were torn down. Just beyond Tracy we were delayed probably half an hour on account of the railroad bridge being somewhat damaged. Beyond the bridge the ground had sunk for some distance from twelve to fourteen inches.

From this on to Oakland we saw evidences of the havoc wrought by the earthquake. Almost all of the chimneys were thrown down. Cracks in the ground were seen along the road in many places.

From Tracy we could see the great volumes of smoke arising from the city, and knew that there must be an immense fire. We arrived at Oakland Mole about two hours late, the train having to go from Tracy to that point without wire communication. The ferry boat had stopped by this time,

and we were not all allowed to cross the bay.

From friends whom I met, who had just come across from San Francisco, I ascertained that my relatives in San Francisco and friends who were members of the Medical Association and Knights of Templars, who were in session in San Francisco, were all safe.

From San Francisco, Oakland and Berkeley doctors I found that there was nothing that I could do in the way of helping the injured. I was informed that there were more than enough physicians and nurses to take care of the wounded, and as it was entirely useless for me to remain on that account and as I had heard repeated reports that Los Angeles had fared far worse than San Francisco, I took the evening "Owl" for home.

Just before leaving I walked out to the Oakland Mole, where I had a commanding view of the entire city. It is impossible to picture the sight before me. A fire extending from near Telegraph Hill almost to the Union Iron Works, with dense volumes of smoke and large flames extending along the entire distance. It is an impression that will be indelibly stamped upon my brain.

## BY THOS. J. MCCOY, LOS ANGELES.

I was stopping at the Hotel Cecil and was suddenly awakened about 5:14 o'clock on that morning, and found that we were having an earthquake. I remember having three distinct impressions: First, that it was an earthquake, and attempted to shield my face from the falling plaster with the bed clothes, and then thought that I would get under the mattress, but it occurred to me that if much plastering fell I would smother. By this time the sound of falling walls and the screaming of the people was terrible, and the building was shaking so that I thought positively

that it would fall any minute, and I had a sensation as though I were falling down a shaft. When the shaking stopped, I jumped from the bed, hearing screams in the halls, and rushed out. I met a lady standing in the hall screaming and told her to go back to her room and rest as it was all over. She told me to look into her room, and I saw the beds, chairs and dresser all piled together in the center of the room. Then a man, who was accustomed to taking a morning bath, and who had filled the bathtub for that purpose, told me to come and look at it; I found

that all but one-fourth of the water had all been thrown out by the violence of the earthquake. I rapidly dressed and went down through the building quieting those whom I could and rendering all the assistance possible. The elevator-shaft had been twisted and the stairs were racked. The fifth and sixth floors of the hotel had fallen out at the back of the building and the front was leaning forward. When the Chief of Police arrived, he condemned the building and would not allow us to go in it. One thing remarkable about it all was that no one in our hotel was very seriously injured. The janitor told me that he was sweeping the front hall when the quake came, and said that the buildings were swaying back and forth just like trees in a heavy wind.

After attending to a young lady who had been thrown down stairs and who had broken her back, I assisted in digging out a woman in a building close by, as the bricks had fallen on her bed.

The excitement had different effects upon different people, most of them seemed dazed, not knowing what to do, all feeling that more quakes might come at any minute. We found that fire had started almost immediately in a half-dozen different spots in the city. By 9 o'clock the fire had gained considerable progress on Commercial Street, approaching Market Street. People were moving, carrying what articles they could snatch from the ruined homes, in various ways, some in street carts, some in pillow slips and in every conceivable manner. The faces of some were flushed with excitement and of others pinched and drawn. One thing I noticed which struck me as being very strange, and that was that the walls of buildings had a tendency to fall out, and most of the danger was in the streets, excepting in those buildings which collapsed, which were frame mostly. Near our street, the walls of one building had fallen first and another building opposite had

also fallen later, lapping over the other in the street. Had the quake occurred in the day time, or rather later on in the day, the number of injured and loss of life would have been appalling.

At that time we heard that Los Angeles was suffering even more severely than we, which made us very desirous of getting a wire home. I started at Twenty-fifth and Valencia Street to see if I could find a way to send word; I found the people moving in great crowds towards the hills and parks; there was the greatest confusion. I think that nine-tenths of the damage was done by fire. As I passed the Valencia Hotel they had already taken out nine bodies, and as the water mains were broken, the people were drowned in the cellars of this building. This building collapsed and went into the cellar. Just back of the hotel the street had moved probably about eight feet, making a curve to it, moving the street, sidewalks and houses. Near by this was a fissure which was about 19 inches wide, filled with water and mud. The afternoon of the same day I saw an Italian attempt to build a fire and an officer ordered him to desist, but he would not and the officer shot him down. The excitement was intense.

Dr. Snow, Dr. Van Zwalenburg and myself wandered about during the afternoon and finally secured a train for San Jose at 7 o'clock that evening. As we viewed the burning city from the hills on the west, there seemed to be about four miles of continuous fire. Thousands of people viewed the fire from the hill tops.

At San Jose we found Dr. Kress wrapped in blankets on the porch of an apartment house, and here we secured quarters for the night. The Coast Line not running, we decided to go north to Niles, but changed our minds and went on to Oakland, where we were fortunate in securing berths on the second train to the South.



## BY WOODS HUTCHINSON, ARROWHEAD HOT SPRINGS.

It was like being in a treetop in a storm. The building swayed to one side and was jerked quickly to the other, and then back again five or six times. It then settled down and the great building was in as good condition as ever, so far as its being habitable was concerned. The structure was practically uninjured. In the eleventh and twelfth stories the swaying was more gentle, and the jerking less noticeable and there were a few cracks in the ceiling, but that was all. In the lower floors there was some fallen plaster. The steel structure saved the building. Those in the upper floors did not realize so much as those nearer the ground the severity of the shock.

Every one seemed to be perfectly calm. I went down to the lower floors to see if there was any fire, then went all the way up through the building, examining the condition of the rooms, and seeing whether there were any sick in need of assistance, should there be necessity for hastening from the building. I found the bell boys doing the same thing. Everywhere there was calmness and order. We had plenty of time. When we saw the fires coming in the direction of the hotel we made preparation to leave and had from 5:15 in the morning to 1. that night before abandoning the hotel. I thought I might be compelled to camp for some time, so took a blanket, went to a grocer's near by and bought some canned goods and crackers. I was charged the regular price for these things. I then walked along away from the fires until I came to a vacant lot where I could find room to spread my blankets under a tree, turned in and slept until 6 o'clock the next morning. It so happened that I was in the midst of some of the roughs and toughs of the city, some of the outcasts from the lower quarters, and I thought it rather

unsafe to be among them in the darkness, but I soon saw my mistake. Every one was as calm and orderly as in one of the parlors of the most refined. Each was intent on making conditions comfortable for those dependent upon them, or for themselves. The men were looking after the low as carefully as the rich. There was no harsh word spoken, no swearing or vulgarity. It was marvelously touching. Not in the whole time did I hear a woman scream and only now and then one sobbed to herself as she thought of the greatness of her loss, or feared for the safety of some friend or relative. But for the most part families were not separated.

After awakening the next morning from the first night's rest in the open air, I saw the fires approaching our retreat, and I thought it time to "dig out," so went down to Black Point and Mason Barracks. At the barracks I found the soldiers distributing coffee already, so I got a cup, then went along the water front to Fulton Ferry, where I crossed over to Oakland about 9 a.m. You would not know that anything had happened except that most of the people carried bundles. There was no more congestion than on many other days. Most of the people thought it impossible to get out of the city, as the report was current that the ferry building had toppled into the bay, and the ships were destroyed. But they were in good working order then and running regularly. Along the water front the fire had left a fringe of buildings. But the circle of fire formed within two hours after the great shock in the morning from the Townsend street station out past the Fulton street ferry into Chinatown, and people thought the avenue of retreat across the bay cut off.

Of course the stories from there have been greatly exaggerated. The story that wounded men were left in the

Mechanic's Pavilion to burn, having been abandoned when the fire approached, is not true. I was there before the fire reached the place. When it was yet a quarter of a mile away all the wounded were removed. There were, however, possibly a dozen bodies of dead that could not be taken away, and they were probably burned, and some one seeing them piled in the building undoubtedly started the story that wounded were left there to perish in the flames.

How much worse it would have been

may be seen from the following incident. Had the shock come a few hours later the death roll would have run up into the thousands, as this incident shows. A band of twenty cattle was being taken down Market street to be slaughtered, every one of which was killed by falling cornices, upper stories of buildings and beams. The streets would have been thronged with people in the portion suffering most from the shock, and the majority of those upon the streets would have been slain.

### BY GEORGE H. KRESS, LOS ANGELES.

Upon being awakened by the rattling windows and creaking walls, I realized almost immediately that the cause of the disturbance must be an earthquake, but no plaster falling, I remained in bed, being annoyed rather than frightened by the manner in which the swaying of the room continued. As my room was on the second floor and had a fire escape at the window, I saw no occasion for alarm. Upon going to the window, I was further reassured by a woman who thrust her head out of the window in a house opposite, looked up and down the street, and then closed the window as if nothing had happened. Her actions led me to believe that these were the kind of earthquakes they had in San Francisco. But the excited conversation of the guests in the hallways of the hotel soon led me to think differently and I dressed, locked my room and went down to the street, where I found many people, men and women in all conditions of array, excitedly moving up and down the thoroughfare, discussing the quake with neighbors and passers-by. Walking down towards Market street, I passed the Y. M. C. A. building, the meeting place of the State Medical Society. The street at this point was filled with much debris from the cornices and chimneys of the buildings

and a similar condition was to be seen on all the side streets. Walking down Market street, I surveyed the damage done to the larger buildings. Some distance down on Market, below Third, I noticed dense volumes of smoke on each side of the street and about six squares below Market, on Third street, a fire was blazing fiercely. So also on Fifth and Sixth streets, south of Market, houses were burning. In other parts of the city toward the bay smoke could also be seen.

I returned to the hotel and met Drs. Frank and Rose Bullard, who had just come down and who did not realize the nature of the catastrophe, nor did they, until they had traveled down to Market street and seen the damage. Returning with them, I packed my satchel and left it in the office, for the situation appeared to me a grave one. After breakfast, with Dr. John C. King and his wife and Doctors Bullard, I went to Union Square Park, which by this time was filled with many fugitives from the flames. Here we met Doctors Fitch Mattison, W. E. Hibbard and C. Lee King of Pasadena, who were acting as gallant knights to a fellow townswoman, Mrs. Linnard. When I discovered that they were sitting on a bench under the Dewey monument, and they said they would join

our party later. I left them and a few moments later there was a slight shock. Looking in the direction of my Pasadena friends, I saw the tall forms of Dr. Hibbard and Mrs. Linard leading the Pasadena hosts in a rapid if not very dignified retreat, while Doctors Lee King and Mattison were stumbling over one another in a desire to see who could run the faster along the same narrow path. This experience led to a reunion of the Southern California contingent and it was decided to hire an express wagon, lay in a store of provisions and adjourn to the Golden Gate Park, when Dr. Mattison's uncle put in an appearance and stated that he thought he could pilot us through Chinatown to the North Beach, where we could obtain a launch and so reach Oakland.

Doctors John C. King and Bullard, with their wives decided to rescue their baggage and to try the Golden Gate Park, but Doctors Mattison, Hibbard, Lee King, Kress and Mrs. Linard availed themselves of this opportunity to leave the stricken city. In this new pedestrian match through the burning district of Chinatown, the party was led by Doctor Mattison's uncle, the rear being brought up by Doctors Mattison and Lee King, who, though much out of breath, and blowing like porpoises, faltered not a moment in putting up a brave and strong front of endurance. At the North Beach we found a launch and reached

Oakland, where our party met Dr. Visscher. Doctors Hibbard and King left for the South on the first train out, Doctor Mattison went on to Alameda, and Doctors Visscher and Kress went south to San Jose.

Here the last two found quarters in a partially wrecked apartment house where they were joined later in the night by Doctors Van Zwalenburg of Riverside and McCoy of Los Angeles. Adventures did not cease at San Jose. A whole story could be made of the experiences of Dr. Visscher at this place, as well as of the Van Zwalenburg mystery which was partially "drawn out" on the train to Oakland next morning. On this train we met Dr. Z. T. Malaby of Pasadena, and on the south bound train which left Oakland for Los Angeles on Thursday morning we found Doctors Wood Hutchinson of Arrowhead Hot Springs, C. D. Ball of Santa Ana, F. M. Pottenger of Monrovia. At Merced, where the telegraph agent told us he had an open line to Los Angeles, a whole mass of telegrams were sent, nearly all of which were received by their senders some six days later. The party reached Los Angeles Friday morning, glad to be home and to find that the City of the Angels had suffered none of the dire mishaps chronicled on the bulletin boards of Oakland, but which the Los Angeles men had, almost to a man, refused to really accept and believe.

## THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.\*

BY CHAS. C. BROWNING, MEDICAL DIRECTOR, POTTENGER SANATORIUM, MONROVIA, CAL.

In view of the vast amount that has been written recently on this subject, an apology might seem to be due for introducing it for your consideration; but the importance of this subject to physicians in general is sufficient excuse for its very frequent consideration, be-

cause the chances of recovery are very materially decreased in proportion to the lateness of the diagnosis and the beginning of treatment.

In the average cases of incipient tuberculosis, at least seventy-five per cent. should recover, if the disease is recog-

\*Read before the Orange County Medical Society, March 6, 1906.



nized and properly treated in from three to five months.

It is not my purpose to go extensively into the subject of diagnosis, about which so much has been written, nor do I expect to present anything new; but I desire to emphasize a few of the salient points of early diagnosis.

One of the obstacles to be overcome is the reluctance of the practitioner to make a diagnosis of tuberculosis.

The time was when there was little offered in the way of hope from proper care, and the physicians may have been justified in keeping the patient in ignorance of his real condition, but with our present knowledge of the hopefulness of recovery, and the dangers to friends from a patient, and the patient himself, who does not know of the existence of the disease and that he should take proper precautions, it becomes plainly the duty of the physician to acquaint the patient with his condition at the earliest possible moment, pointing out the hope of recovery and giving instructions for his welfare and the welfare of his friends.

I hope that you will permit me to digress sufficiently at this point to state that the careful, intelligent, properly directed tubercular patient is not a menace to those with whom he associates, and the precautions which are necessary for the protection of the general public are only such as are necessary for his best interests as regards his chances of recovery.

A personal history cannot always be obtained accurately, but the history of catching cold easily or being subject to colds should arouse suspicion. Frequently coughing following laughing may be an early symptom. The history of loss of weight accompanied by tired feeling not satisfactorily accounted for by yourselves, for the patients can frequently account for such loss satisfactorily to themselves, should excite grave suspicion.

The physical examination, which will

be your main reliance, should be thoroughly and systematically carried out in every case, with the patient stripped to the waist. Inspection may reveal an asymmetry in contour or movements of the chest which may excite suspicion, but these will probably come later, when the disease is well marked and easily diagnosed.

Percussion will, in many instances, reveal to the trained ear slight differences in pitch, when comparing the corresponding areas in the different sides of the chest, which is not accounted for physiologically. This difference may be heightened by percussion during forced inspiration or expiration and any difference not satisfactorily accounted for should arouse suspicion.

Auscultation will probably be the method which will be most largely depended upon to determine the probable differences. This may be either mediate or immediate and the physician should familiarize himself with methods and instruments which appear to him in his particular locality, to offer greatest advantages and study them sufficiently to become proficient in their use.

The stethoscope which the writer prefers, von Ruck, is one which will as far as possible exclude external sounds; will limit the sound as far as possible to the area immediately under the stethoscope, and will neither accentuate nor diminish the sound or change its quality more than can be avoided. The one which I use can only be used on the bare skin. I am thus never tempted to make a hasty examination over the clothing, and am in the fortunate position, should any one through modesty or otherwise object to exposing the surface of the body for examination, to state that it is impossible for me to make an examination otherwise. You are all familiar with the soft respiratory murmur of normal respiration. Diminution of the respiratory sounds or any roughness, however slight, not satisfactorily accounted for, are symp-

toms which should cause a thorough investigation of the case for the beginning of tuberculosis, for such symptoms are always abnormal.

If added to one of these departures, there is a slight, prolonged expiratory sound, the case becomes much more probably one of tuberculosis, especially if found only on one side.

The foregoing signs are quite suggestive, but may occur where there is a healed pulmonary lesion. Another early symptom is the fine rales, which may be heard on ordinary respiration, but at times can only be elicited by deep breathing or following a cough. They resemble closely the rales of croupous pneumonia, but if they occur in isolated small areas in connection with other early symptoms of pulmonary tuberculosis, or lacking the accompanying symptoms of other diseases, there is no more suggestive sign of incipient tuberculosis.

Another symptom of value is the transmission of the human voice, either spoken audibly or whispered over an area of consolidation. This symptom never occurs in normal conditions.

The pulse rate is usually accelerated, but the variations of the pulse within normal limits is so great as to render this symptom of comparatively little value in the early stages, unless we may be able to determine the normal pulse rate of the individual. The temperature variations from the normal are of greater importance, and any variation either above or below the normal, not otherwise satisfactorily accounted for, should arouse suspicion. In the early stages of tuberculosis, the sub-normal temperature is very frequent, particularly during a period of quiescence of the process.

In the early stage cases at our Sanatorium and in others, when the process becomes inactive, a temperature of 97 is of frequent occurrence. A low temperature, not satisfactorily ac-

counted for would, to me, appear as a very probable symptom of tuberculosis. If taken in connection with the one or two auscultatory symptoms would be sufficient for a strong presumptive diagnosis. Cough may be present or absent during the incipient stage, and may be elicited only following exertion or laughing, and in proportion to its frequency will probably be the amount of sputum. The sputum may vary in quantity and character so greatly that in itself it is of little diagnostic value.

The microscope findings in the sputum, if tubercle bacilli are present, is of course positive evidence of the existence of tuberculosis, but the absence of such findings are no evidence that tuberculosis does not exist. With the exception of rare instances of infection in the bronchial tubes or bronchial glands, the microscope very seldom, if ever, reveals the presence of tuberculosis before it may be revealed by physical signs, and frequently the conditions are so late in manifesting themselves, by which tubercle bacilli are found in the sputum, that the case has passed beyond what may be fairly termed the incipient stage. Other organisms, the streptococci and other pus producing germs, may be found in sufficient quantity for weeks or probably months before the appearance of the tubercle bacilli to account satisfactorily to the mind of the examining physician for all the symptoms manifest, and in this way a very careful, pains-taking examiner may be misled.

Great as the good which has been accomplished by the use of the microscope in this disease, I cannot but urge upon your attention the great harm which may follow waiting for the demonstrations of the bacilli before admitting the existence of tuberculosis.

Another means of diagnosis which as yet has not come into general use, but I feel sure I am safe in saying, is coming into favor among those who are giving special attention to the

cure of tuberculosis, is the tuberculin test in these early cases.

The rule has been with many to give from five to ten milligrams of tuberculin and await the reaction, which is manifest by two or more degrees rise of temperature in six to twenty-four hours, together with aching and other nervous manifestations. This has been objected to on the part of some, because of the inconvenience occasioned, and some have claimed that acute symptoms have been produced which were dilatorious to the patient.

Without stopping to discuss this matter fully at present, will state, I think it is generally considered that when the reaction occurs, the diagnosis is positive, and I am inclined to believe that in the large majority of instances in which acute symptoms have followed the use, it has been a coincidence, and that the good which may be derived from the early diagnosis far exceeds an occasional ill effect, granting that such is the case. However, I do not believe it necessary to produce this train of symptoms, in order to make a positive diagnosis.

For several months we have been in the habit of giving our patients a temperature chart, and if possible, taking them to the Sanatorium for 24 to 48 hours preceding the test. We insist on the patient avoiding excessive exercise. We have the temperature taken every two hours during the waking hours of the patient, and we observe from time to time the condition of the suspected points in the chest by the aid of the stethoscope. About 9 p. m., we give three millimetres of tuberculin and the next morning note the general condition of the patient as regards temperature and general feeling. But what is of especial interest to us is the condition shown in the suspected area. If there is local involvement at the pharynx, ear, or larynx, we note in the area of the involvement the capillary blood-vessels are enlarged and

there are symptoms indicative of congestion or mild degree of inflammation, or in the lung tissue we find the fine rales are manifest, where they may have been absent previously; or where they were suspected we find them pronounced and suspicious. In this manner if we get the physical signs of the tuberculin reaction, we avoid the disagreeable systemic symptoms. The most that is complained of is a slight nervous feeling and some slight malaise, and probably a half degree to one degree rise of temperature, unless the patient is unusually susceptible to the influence of tuberculin, and it would be in this class of cases which we would get a violent reaction with the larger dose.

We were led to the conclusion that this is an accurate diagnostic agent used in this manner, as well as used in the larger doses, from our constant use of tuberculin or the watery extract of tubercle bacilli, which acts in a similar manner, on an average of about sixty-five patients per day in the treatment of tuberculosis.

In those cases where the careful watching for these conditions was made, we very rarely produced a reaction, nor an increase in temperature of more than a degree, unless we did so purposely to accomplish a certain result. I believe that used in this manner, the agent is not only reliable, but free from harm and should be resorted to in doubtful cases.

I believe it better that we should be in error in diagnosing a case of probable tuberculosis, and giving the tuberculin test, and instructing the patient how he should conduct himself, even though the more previous symptoms should not be developed, than by waiting for the ordinary positive symptoms, as the appearance of the bacilli in the sputum, jeopardize the patient's chances of recovery or at least cause him to be subject to a longer course of treatment with the greater liability to the complications.

I believe that in an early case we may



more reasonably hope that by the stimulation produced by an injection of a reasonable dose of tuberculin, that

we may cause the disease to be arrested, than that harm may come from such injection.

## A NEW METHOD OF STERILIZING CATGUT.\*

TRANSLATED FOR THE PRACTITIONER FROM "CENTRALEBLATT FÜR CHIRURGIE," NO. 44.

BY P. C. H. PAHL, B.S., M.D., LOS ANGELES, CAL.

The method discovered by Prof. Dr. Oscar Bloch, in the surgical laboratory of the Kgl. Frederiks Hospital at Copenhagen, and clinically proven in that Hospital, is as follows:—

The ordinary catgut of commerce is wound on glass spools, care being taken not to wind too much nor too tightly, so as to prevent the underlying strands from coming in contact with the solutions. Without any preliminary preparation the wound spools are placed in an aqueous solution of iodine and iodide of potash, (Iodine 1 part, Potassium Iodide 1 part and Distilled Water 100 parts; dissolve the K. I. in a small quantity of water, then add the finely powdered iodine. When dissolved, add the rest of the water.)

The solution is placed in a glass stoppered jar of suitable size which is labelled and dated and, at the end of eight days, the catgut is ready for use and is allowed to remain in the same solution and container for indefinite preservation. When it is to be used, the spool is removed, it is rinsed in a 3 per cent carbolic acid or any other sterile liquid whereby the surplus solution is washed off. The ligatures are cut off in the carbolic acid solution and that which is unused is placed back in the jar.

This method of preparing catgut makes the gut very dark and it assumes a peculiar consistency which is, at the same time, pliable and elastic—not unlike a thin copper wire, and is very readily tied.

This method of sterilization is absolutely safe as shown by Dr. Claudius through extensive laboratory experiments. The ligature is not only sterile, but, through the iodine which it contains, actively antiseptic, so that handling it with the hands is not liable to infect it. It is absorbed in from twelve to sixteen days, perhaps somewhat slower than the carbolic acid and alcohol prepared gut. Local irritation is not produced by the poisonous action of the iodine, for the reason that the pure iodine in the tissue soon forms non-irritating substances.

### WHAT HAVE YOU DONE TODAY?

We shall do much in the years to come;

But what have we done today?

We shall give our gold in a princely sum;

But what did we give today?

We shall lift the heart and dry the tear,  
We shall plant a hope in the place of fear,

We shall speak the words of love and cheer;

But what did we speak today?

We shall be so kind in the after-while;

But what have we been today?

We shall bring to each lonely life a smile;

But what have we brought today?

We shall give to truth a grander birth,  
We shall feed the hungry souls of earth;

But, this is the thing our hearts must ask:

What have we done today?

\* I. M. Claudius. Deutsche Zeitschrift für Chirurgie. Bd. LXIV, page 489.

# SOUTHERN CALIFORNIA PRACTITIONER.

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

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## EDITORIAL.

### CATS, DOGS, FLIES AND MOSQUITOES AS DISTRIBUTORS OF INFECTIOUS DISEASES.

There is no doubt but that insects and domestic animals—"household pets"—are the great disseminators of communicable diseases.

"Sore" eyes, "sore" throat and many other common afflictions of children are due to the dog, the cat or the fly. The dog or the cat has its nose in the disease bearing expectoration of the street and within a few minutes is being kissed and fondled by the child.

"Fight the flies" should be the slogan in every household, restaurant and hotel. Every nurse should see to it that not a fly should enter her patient's room. The fly is filthy and dangerous. The substitution of the automobile for the horse and the garage for the stable is reducing materially the breeding places

for flies. The *Los Angeles Examiner*, of recent date, editorially says:

"The human race has done pretty thoroughly the work of killing off earth's big monsters.

"The dangerous animal is a curiosity rather than a menace.

"In India the snakes still take a good many lives; the tigers take a few. Here and there governments offer rewards for dead wolves and other big things.

"But human beings are practically through with the fight which has occupied them for centuries—the fight to get possession of the earth by driving the big monsters off it.

\* \* \*

"Science as usual teaches us, however, that our work of extermination has only begun.

The biggest mammoth that ever rushed through the old forests, destroy-

ing a family or a dozen families in his heavy, slow progress, was a small danger indeed compared with one single buzzing mosquito in New Orleans.

"The Government of the United States is fighting the New Orleans mosquito and the Cuban mosquito—carrying the deadly yellow fever germ—more vigorously than any government ever fought bears or wolves.

\* \* \*

"Rats are the vile agents that distribute bubonic plague and cholera. They carry the germs with them and kill their thousands in the East.

"The mosquito distributes yellow fever and malaria. *It is impossible for a human being to get those two diseases except from the mosquito's bite or by direct inoculation.*

"Marvelous to relate, certain disease germs are only harmful to man after passing through the digestive apparatus of some lower animal.

"We have recently learned that pneumonia, supposed hitherto to be due to a chill, a current of air, is, in reality, due to a vicious germ, and that *the ordinary house mouse is the carrier of the germ.*

"Science now says that pneumonia doesn't come from catching cold, and can be stopped by catching mice.

"*That is literally true. The young mice especially are infected with the microbe of pneumonia, and the bodies of these tiny creatures, dissected recently, have shown the pneumonia germ in great numbers.*

"Therefore, citizens of the United States, catch your mice and you need not be afraid of catching pneumonia.

\* \* \*

"The house fly also carries diseases—

all kinds of germs on its sticky little feet.

"The human race sooner or later must systematically combine to destroy these almost invisible enemies, so much more dangerous than any wild beast.

"The man who dries up swamps where mosquitoes breed, or who covers with netting a half empty barrel, is a benefactor to his kind.

"The tidy cook spreading her sheets of fly paper about is doing a great deal to cut down disease. The cat catching the mice helps to do away with pneumonia—although the baby may get the germs if he is allowed to grab the cat and hug it just after the mouse has been eaten.

"Do your share, in an erratic, disorganized manner, to kill off the enemies of mankind—flies, mice and rats—while waiting for the government to do the work in an organized fashion.

\* \* \*

"If you have young children, keep them away from the foolish, out-of-date 'household pets.'

"If the savage instinct survives in you from your old ancestors so strongly that you *must* have a dog around, at least teach the dog not to lick the faces of children, and teach the children not to bury their faces in the animal's fur. Keep cats, with their germ-laden bodies away from your little children.

"Even a doctor with whiskers carefully combed, washed and disinfected is out of place among children. Each whisker may be a microbe's perch. How much worse it is to have among your children animals covered with fur, especially animals like dogs, that are



forever eating what is unclean, and that necessarily brings disease into the house from every expedition."

### AN EARTHQUAKE SYMPOSIUM.

In this issue of the *PRACTITIONER* we print the earthquake experiences and impressions of some of our Southern California colleagues who were in attendance at the semi-centennial meeting of the Medical Society of the State of California, at the time of the San Francisco cataclysm.

The semi-centennial meeting will be probably known as the great San Francisco earthquake meeting. As a matter of historical preservation in a medical publication, as well as because of the personal interest attached to the experiences of our fellow practitioners from the South, we are glad to give space to this unique symposium which, though it may be of little scientific, should nevertheless be of considerable personal interest to medical practitioners of the Southwest.

### THE DEATH OF DR. CHARLES F. TAGGART.

The death of Charles F. Taggart of Los Angeles was a great shock to his many, many friends. The Doctor was in San Francisco devoting his time and energies to the work there, having left Los Angeles the day after the earthquake. He was one of the first on the field, and while others returned and urged him to come with them, yet he would not leave his place of duty. The revolver which he was carrying at the time went off accidentally while in his pocket and the bullet ranged up and penetrated his heart. Dr. Taggart was

one of those nervous, generous, energetic, great-hearted men. He was an able surgeon and a devoted and self-sacrificing friend to every patient. At his funeral in Los Angeles large numbers of the profession were present. Probably no person has ever been more sincerely mourned than he. His wife and daughter have the deep sympathy of the profession.

### THE STATUS LYMPHATICUS.

At the April Clinical Meeting of the Los Angeles County Medical Association Dr. Stanley Black, presented several admirably mounted specimens, showing the enlarged lymphoid elements in the gastro-intestinal tract as met with in the somewhat obscure condition known as the Status Lymphaticus.

Dr. Black gave a brief resumé of our knowledge of the condition and among other things, stated that the medico-legal examiners and pathologists of Vienna looked for this condition in every case of death during operation or from anaesthesia and that the presence of these enlarged lymphoid elements, with an enlarged thymus, in the absence of any other lesions, was always accepted as absolving operator or anaesthetist from blame for death on the operating table. The significance of the condition was therefore of considerable practical importance.

As illustrating this point, about two weeks after this talk, one of the best known and most careful of Los Angeles' anaesthetists had a patient die suddenly while some teeth were being extracted. The anaesthetic used was bromide of ethyl, for the use of which there were

no contra-indications, and which was taken nicely until of a sudden respiration became jerky, then better, then stopping entirely, all the usual modes of stimulation and artificial respiration being of no avail.

The anaesthetist insisted on a coroner's inquest and post-mortem, the autopsy being made by Dr. Black, who found the enlargement of the lymphoid elements characteristic of the Status Lymphaticus.

The pathology of the condition is still meagre, but is sufficiently well established to give it a firm basis and place among disease states.

As it may be responsible for unforeseen and non-preventable accidents in anaesthesia and on the operating table it is worthy of remembrance by all, lest anaesthetist or surgeon be unjustly blamed for a death which as yet we have no means of foreseeing or preventing.

#### THE EYE, EAR, NOSE AND THROAT SECTION OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION ENTERTAINS.

On Friday evening, May 11th, the Eye Ear, Nose and Throat Section held an open meeting to which all members of our County Medical were specially invited. The papers of the evening were devoted to a symposium on Mastoiditis, the full proceedings of this part of the programme being recorded in the Society Transactions department of the current issue of the *PROCTHETOR*. The Symposium was intended to bring out the importance of early diagnosis of middle ear disease, so that the fatal brain complications as well as defects in hearing might be avoided. Following the

scientific programme a buffet supper was served by the Section to the members present. This buffet lunch, by the way, was most enjoyable, and its success was largely due to the fact that the members, instead of being served by attendants, served themselves and one another. It is curious to what a great degree the extension of these little courtesies, such as the passing of food to one another, help break down the barriers of reserve and ultra-politeness, and lead to pleasant acquaintanceship, understanding, and oftentimes friendship.

The Eye, Ear, Nose and Throat section, since its organization a little more than a year ago, has made a most excellent record for itself in its particular field, and its members are proud of the scientific work it has put forth, as well as of the better understanding it has led to among the men who practice these branches of medicine and surgery.

It is pleasant to know also that their specialism has not made them narrow, but that on the contrary, they not only invite all members of the Association to their meetings but that from time to time, they intend to strengthen this better understanding with general practitioners, by meetings such as that recently held.

#### THE SCREW WORM OR BLOW FLY DISEASE.

Attention has been called of late to the need of the medical profession being on the alert for sporadic cases of some of the tropical diseases, imported into our country from time to time, through returning soldiers or immigrants coming from our tropical possessions.

We must all confess that our knowledge of many tropical diseases is still in its infancy, and that even in our own Southland there is much to be learned about certain infective fevers. At the last meeting of the Pasadena Branch of the Los Angeles County Medical Association, an account of which appears under the Society Transactions column, a report was made by Doctors Royal, Crance and Hibbard concerning two cases of screw worm or blow-fly infection of the nasal sinuses, in which it was necessary to resort to radical operative measures in order to save the patients' lives.

The *Standard Dictionary* says the "screw worm is the larva of an American blow-fly, bred in sores on living animals, or in the nostrils, navel, etc., often with fatal effect. It occasionally attacks human beings." We do not believe very many of the text books mention the condition, and as it may be a very serious and even fatal one, and as Pasadena reports two cases for last year, it may be well to be on the lookout for it.

In both the Pasadena cases reported the blow-fly had evidently entered the nostril, deposited the eggs in the mucosa, the larvae or screw worms making their way into the accessory sinuses, "eating everything in sight," with the result of waxing fat, but giving their unhappy hosts most serious and distressing experiences. The symptoms were those of pyogenic infection of the accessory sinuses by the ordinary suppurative micro-organisms. The macroscopical nature of the condition impressed itself on Dr. Royal's mind, when

in trying to prove a sinus, he extracted with forceps a large succulent screw worm from one-quarter to one-half an inch in size. Both cases were operated upon by Dr. Hibbard, free extirpation of the diseased tissues in all the accessory sinuses being necessary.

With two cases in Pasadena in one year, the question suggests itself as to whether or not there have not been other cases of infection by this pest in this locality, which may have escaped observation.

#### THE APRIL SAN FRANCISCO EXAMINATIONS OF THE CALIFORNIA STATE BOARD OF MEDICAL EXAMINERS.

We print below a letter from Dr. John C. King, President of the State Board of Examiners, in regard to the action taken by the Board in passing the applicants who appeared before it in April, at the time of the San Francisco earthquake.

We are sure that the action of the Board will meet with the approbation of the profession.

Dr. King's letter is as follows:

Banning, Cal., May 12, 1906.

My Dear Doctor:

At Arrowhead I told you the California State Board of Medical Examiners was considering the advisability of granting certificates to all candidates who had achieved 60 per cent. on any two of the first day's papers (Bacteriology, Physiology and Pathology), for the following reasons:

1. The examiners could "mark up" the papers to 75 per cent. because,

2. Those who made 60 per cent. on above subjects could, judging from some years' experience, average 75 per cent. on all.

3. The Universities, Stanford and Berkeley, and Hastings Law School are, I am informed, about to issue diplomas without examination, to all of their senior students who are not manifestly unworthy—on past record of work.



4. These applicants had, many if not most of them, lost all their baggage and (in many cases) were out of money and could not attend another examination.

5. They were there in good faith ready to be examined. It was up to the Board to provide facilities for the examination and to conduct it. The Board after the first day, did not do so. Perhaps the court would hold that the applicant had complied with all necessary conditions and was entitled, through default of the Board, to a license.

6. The occasion having been what the courts term an "Act of God," it would not establish a precedent—except in case of another earthquake and fire.

The members of the Board, all except one or two, agreed with this view of the situation, especially as many applicants had done heroic rescue and other work for the stricken people. The attorney for the Board, I am led to believe, approved the plan but thought best to have the legal question submitted to the Attorney General of the State. This was done and the Attorney General's approval secured. New certificates were printed, a new seal secured, (we lost everything in the fire), and a few days ago I signed and returned to our Secretary 51 licenses. There were 58 applicants. I have not yet learned whether the remaining 7—or part of them—failed to appear for examination or whether they fell below 60 per cent, so flagrantly that our Examiners could not conscientiously pass them. All addresses of applicants were lost, but fortunately I had a list of their names, college and date of graduation. If you meet any who do not within reasonable time receive papers, tell them to send present address to our Secretary, Dr. Charles L. Tisdale, Alameda, Cal.

I think the above statement covers all points of your inquiry. You are at liberty to use it. . . . The Board acted as a unit, and to the Board the applicants should give credit for their good fortune in not being required to repeat their effort.

Yours,

JOHN C. KING.

#### FINANCIAL AID FOR THE PHYSICIANS OF SAN FRANCISCO.

The great American nation, maligned at home and abroad as a materialistic people of an aggravated type, put the lie to these uncomplimentary assertions

when the news of the San Francisco earthquake was flashed across the country, by the magnificent manner in which the nation and the people extended their sympathy and aid to the stricken city. With the main phases of the relief work all are familiar. The loss of property was so great and universal that comparatively little has been written about individual privations.

Among the residents who remained on the ground few have done more work for their fellows than the members of the medical profession. At the same time no profession has suffered so much in material losses. Homes, offices, instruments, libraries and even the clientele of many a San Francisco colleague have disappeared. The distress of many of our San Francisco confreres is real and great and their needs are worthy of the very creditable generosity and thoughtfulness manifested by Eastern colleagues who have been sending contributions to the *Journal of the American Medical Association*.

Los Angeles physicians have, through the various organizations of our city, already contributed several thousand dollars to the relief work in the North, but not satisfied with this, the Los Angeles County Medical Association has appointed a committee to continue the work of raising funds for the special purpose of aiding our medical brethren in the North.

The Pasadena Branch, through its committee consisting of Doctors Mattison, Hibbard, Abbot, Sherry and Radabaugh, has already raised more than two hundred dollars. The committee for the County Medical Association proper consists of Doctors Wills, Fasig, King,

Shurtleff and Collier; for Long Beach of Dr. Jones, and Pomona of Dr. Thomas, and these gentlemen will strive to reach all of the practitioners of the city in the furtherance of the cause for which they were appointed.

#### SAN FRANCISCO AND THINGS MEDICAL.

The *California State Journal of Medicine*, under the editorship of Philip Mills Jones, comes out for May as an eight-page leaflet. Dr. Jones states that they are threatened with a libel suit by Seabury & Johnson, and he advises them to go ahead and sue, and "if they get judgment perhaps the court will allow them to attach the smoke yet hovering over what was once our property." This is but one of the many evidences of the San Francisco calamity. The medical profession suffered great material loss, and a practical interest in them is being manifested from all parts of the United States. The universal testimony is that the physicians of San Francisco and O.kland neglected protecting their own material interests in order to be of use of the sick and wounded. There is no question but San Francisco will be rebuilt and become a more substantial and beautiful city than ever. Immense numbers of people will be employed in this rebuilding, and the San Francisco physician will soon find himself with a large clientele, possibly not the same that he had before the fire. If we were a young man we do not know any place where we would feel more disposed to locate right now than in San Francisco. The comparatively small loss of life during the earthquake and the fire and the freedom from serious illness among refugees and campers are points for congratula-

tion. San Francisco is the metropolis of the Pacific Coast, it is the commercial center of the West, and even fire and earthquake will not deprive it of its supremacy.

#### SOME AFTER-THOUGHTS OF OCCURENCES AT THE SEMI-CENTENNIAL STATE MEDICAL MEETING.

To the City of San Francisco and its environs, Southern California extends its sincerest sympathy in the great catastrophe of earthquake and fire which visited that portion of our State on April 18th and the days following. To our confreres in the medical profession, we likewise express our sorrow at their personal losses in things material, but take pride in the manner in which they have shown themselves, in the practice of their profession in those trying days, to be worthy members of our honorable guild.

\* \* \*

We trust that in the newer and greater San Francisco, which is sure to arise from the ashes of the old, that the members of the medical profession of San Francisco will get together and express in no unmistakable manner their views on the needs of the city, as regards matters of hygiene, sanitation and the public health.

San Francisco has a magnificent opportunity to build a model city and no sordid materialistic influence should be allowed to dominate the Council of the City, to the end of permitting the erection of unsanitary and unhygienic buildings.

The San Francisco County Medical Society will never again have so magnificent an opportunity to do a good and

noble service to the city wherein its members live, as is now before it. In the face of these patent responsibilities and duties, the consideration of abstract scientific dissertations and polemics is as nothing. For the good that will accrue to the welfare of the State as a whole, as well as to the medical profession, we trust that our colleagues of the Golden Gate will give the problems bearing on the public sanitation, hygiene and health of San Francisco their earnest consideration and support.

Not even their magnificent work performed in the practice of their profession during the several weeks just closed, could bring greater credit to the medical men of San Francisco than a united and insistent effort to better the hygienic and public health conditions of the city. We are sure that the able men who represent the art of healing in the North, will not be derelict to their duties in preventive medicine, which now lie before them.

\* \* \*

The semi-centennial meeting of the Medical Society of the State of California, which convened for a three-days' session at San Francisco on Tuesday, April 17th, came to an abrupt and unexpected close, because of the great earthquake which visited the city of the Golden Gate and surrounding country at 5:12 a.m., on Wednesday, April 18th.

\* \* \*

Following past custom, the meetings of Tuesday were given over to the reports of officers and committees and to the organization of the various scientific sections and in the evening, to the first session of the House of Delegates.

The work in all departments had been fairly started and all signs pointed to a very successful and profitable meeting, when the earthquake of April 18th and the great fire of the succeeding three days, which made the larger portion of San Francisco a scene of ruin and of desolation, brought the meeting to a close.

\* \* \*

The election of officers was to have been the first order of business for Wednesday evening. As the second day's sessions were never begun, our officers of last year still remain in power. The constitution of the State Society provides that all officers shall continue as such until their successors are elected. The election must be by the House of Delegates and by ballot. Whether or not it is possible or desirable to attempt to convene the House of Delegates at some future time, is a matter which the State Councilors will decide.

\* \* \*

If it were a matter of President and Secretary alone, it might not be necessary to consider a subsequent meeting of the House of Delegates. It is the election of a new list of nominees for the California State Board of Medical Examiners, on which hinges the importance of such a meeting.

Governor Pardee would no doubt be willing, under the present circumstances, to reappoint the present incumbents, but would this not, perhaps, be a dangerous precedent to establish, and one which some antagonistic governor of the future, might use to subvert the State Medical Law? Would it be wise to establish a precedent, that could at



some future time, be made to endanger the integrity of that law?

\* \* \*

Our State Medical Law, weak though it be in some respects, and harsh as its provisions may seem to be on those who desire to be ethical practitioners, but who for various reasons find the examinations very difficult, is nevertheless, a law that we must all uphold, by all honorable means, no matter at what cost to individuals or to personal feelings and opinions.

The reason why this State Medical Law is paramount to personal opinions of the contrary, is that it works for the welfare of the people and of the profession as a whole, and the rights and privileges of the whole should have precedence over the views and privileges of individuals.

\* \* \*

But firmly as we believe in, and are supporters of the State Medical Law, we do not blind our eyes to the fact that for the time being, it seems to have its harshest application on practitioners who are somewhat lacking in theoretical knowledge of modern medicine, but who desire, nevertheless, to be ethical practitioners; and that the out and out quacks and charlatans, as well as such professedly new schools of the art of treatment as the osteopaths, are quite exempt from its provisions and penalties.

This is a point that should not be lost sight of. In our devotion to the law, because it means a higher toned profession, scientifically, socially and materially, it is not necessary for us to blind ourselves to its limitations.

We should recognize further, that our Board of Medical Examiners is a constantly changing body and that the influx of new blood in the board means a more or less constant change in standard in the questions put to applicants and the manner in which these questions are marked. This change sometimes means a lower, and sometimes an exceedingly high standard.

And it is here, on just this fact, that such criticism of the State Medical Law and the Board of Medical Examiners as may be said to have had a legitimate basis, rests.

\* \* \*

We have never believed for a moment, nor can anything but absolute proof (which we are sure cannot be forthcoming) convince us, than that the gentlemen who in times past have been nominated as examiners by the Medical Society of the State of California have been aught but high-minded and honorable in the performance of their duties as members of the California State Board of Medical Examiners.

\* \* \*

Yet, believing this fact, firmly and uncompromisingly as we do, we must acknowledge to ourselves, that in times past, there has cropped out occasionally what seems to have been a lack of tact or a lack of appreciation of the fact that the State Medical Law was intended primarily, not to show a man's superior knowledge or efficiency in one or more subjects of the medical curriculum, as it was to demonstrate whether or not an applicant possessed medical knowledge and efficiency at least equal to that possessed by the average of the licensed medical practitioners of California.

Because we believe the lack of recognition of these facts may endanger the State Medical Law and because we hold that even the State Board of Medical Examiners has no greater right to endanger that law, through unnecessary and uncalled for severity in its interpretation, than have individual practitioners because some of its provisions do not accord with their individual opinions, we believe it would be desirable, if measures could be instituted, and brought into being, whereby all chance of justifiable criticism could be eliminated.

\* \* \*

We know of no one measure which would relieve the Board of Examiners of the charge of catch questions and which would prevent the sympathy of the public or of the courts being extended to a disappointed applicant, than the practice of each examiner giving in each subject fifteen questions, with choice of ten. If the public were informed that fifteen questions had been given and that the applicant failed to

get the required 75 per cent. on the ten questions of his own choosing, little sympathy would be extended to him. This is a common-sense fact which all who have common sense must recognize.

We would urge, and that most earnestly, that this New York State Board method of fifteen questions, with choice of ten, be adopted by the examiners nominated by the Medical Society of the State of California.

The only additional labor involved would be adding five questions to the lists. But even if more additional labor were involved, our examiners would have no right to shirk work which would place our State Medical Law on a firm foundation, and which would knock the props from under such individuals who openly or in the dark are seeking to destroy that Law and its beneficent intentions.

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Much more might be written on this subject but for the time being, we content ourselves with the above.

## EDITORIAL NOTES.

Dr. George T. Kress has removed from the O. T. Johnson Building, and has taken offices at 506 Bryson Building, at Second and Spring streets.

Dr. Noon, formerly of Nogales, Ariz., has recently located in Cananea, Mex.

Dr. Will E. Lindley, formerly of Douglas, Ariz., has located in Cananea, Mexico.

Dr. Granville MacGowan has sailed for Europe, where he will spend six months.

Dr. W. Harriman Jones and Miss Ida Belle Musselman, both of Long Beach, were married on March 29th.

Dr. Charles D. Stoffer of Gallup, New Mexico, spent a few days in Albuquerque recently.

Dr. A. G. Roundville of Williams, Arizona, has been appointed a member of the Territorial Board of Pharmacy.

Mr. Edward Tonkin Dobbins, second vice-president of John Wyeth & Brother of Philadelphia, died Jan. 19, 1900.

Dr. A. Anderson has recently located in Roswell, New Mexico.

Dr. Robert T. Allen has returned to Redlands and resumed practice.

Dr. Thomas B. Hart of Raton has been attending the New Mexico Medical Society at Albuquerque.

In the fire at San Francisco more than one thousand physicians lost their offices and all equipment.

Dr. E. H. Skipwith of Roswell is president of the Pecos Valley Society of former Kentuckians.

The residence of Dr. W. V. Whitmore, of Tucson, was recently burglarized.

Dr. John W. Foss has been mentioned as a candidate for Mayor of Phoenix, Arizona, but he emphatically declines.

H. F. Rowland of Pasadena has left on an extended trip to Philadelphia, New York and other eastern cities.

Dr. P. M. Jones, Secretary of the State Medical Society, is now located at 1230 Telegraph avenue, Oakland.

Dr. Donald J. Frick of Los Angeles, has removed to the Delta building, 426 South Spring street.

Dr. John R. Haynes and Dr. W. W. Beckett have just returned from a business trip to the City of Mexico.

Dr. W. G. Shadrach of Albuquerque was recently called to his old home in Richmond, Va., on account of the serious illness of his mother.

Dr. James Jackson of Hemet, Cal., has been spending a few days in Los Angeles, assisting in the medical care of San Francisco refugees.

The New Mexico Medical Society held its annual meeting in Albuquerque on May 2nd and 3rd. Dr. P. G. Cornish of Albuquerque presided.

The Deaconess Hospital of Los Angeles has been merged into the Clara Barton Hospital, under the name of the latter.

The Territorial Insane Asylum of Arizona has been having an investigation by the grand jury, and they criticize the asylum board and the steward quite severely.

Dr. C. G. Duncan of Socorro, New Mexico, is very enthusiastic about his home city, and says Socorro is developing steadily and surely.

Dr. Dudley Fulton of Los Angeles leaves the first of June for Vienna, where he will spend a year in hospital and laboratory work.

Dr. A. J. Bouffleur of Rush Medical College recently addressed the Long Beach Medical Society. Subject—"Drainage: Surgical and Medical."

Dr. Ray Ferguson of Nogales has arrived in Phoenix and taken the position of Superintendent of the Territorial Insane Asylum.

Dr. D. C. Barber, superintendent of the Los Angeles County Hospital, says that the prevalence of cancer is increasing to an alarming extent.

Dr. Andrew Stewart Lobingier of Los Angeles was seriously injured in a run-away on April 5th. We are glad to know that he is rapidly recovering.

Dr. Boardman Reed, of Philadelphia, has located permanently in Alhambra, a suburb of Los Angeles. He is now in the East but will return to California in August.

Dr. Norman Bridge is in London on a hurried trip. Dr. Bridge is representing a company that own Mexican oil and mineral lands. Millions of dollars are invested in this great enterprise.

Dr. J. W. Lennox and Miss Ethel Bectel were married in the Episcopal church at Tucson, Arizona, on Thursday, April 12th. The Doctor is located at Helvetia, Arizona.

Dr. C. S. Means, one of the most noted surgeons in the United States, has been elected president of the Board of Education of the city of Columbus, Ohio.



Dr. Chas. Lee King, the well known Pasadena practitioner, had his automobile smashed by an electric car. Very fortunately the Doctor escaped personal injury.

Dr. C. L. Cayen has been chosen Mayor of Bisbee by a large majority. Dr. Cayen is well and favorably known in Los Angeles, and we are all sure that Bisbee has a good mayor.

Drs. Freedman and Sexton, of Los Angeles, were recently the victims of a dangerous runaway. Both were considerably injured, but their injuries were not of a permanent character.

The Audubon Society of Pasadena reports that the Japanese are killing in a wholesale manner the birds of Southern California; that they seem to specially enjoy shooting mocking birds and meadow larks.

The *Quarterly Journal of Inebriety* comes to us in an artistic new garb. The business of this publication has been turned over to Richard G. Badger, publisher of the Gorham Press, Boston, Mass.

Dr. Arthur Manley Burns, who graduated from the Bellevue Hospital Medical College in 1870, and has been practicing medicine in Southern California since 1902, died in San Diego on April 26th.

Two hundred and forty screw worms were removed from the cavities of the nose and the roof of the mouth of a young man from Mexico by Dr. Nicholson, the railroad surgeon at Nogales, Arizona.

We have received Vol. I, No. 1 of the *Bulletin of the University of Nebraska College of Medicine*, published by the University of Lincoln, Nebraska. This is certainly a very creditable publication.

Dr. Henry Sherry, of South Pasadena, is being actively brought forward by his friends for the Republican nomination for state senator. The

Doctor would certainly make a most efficient official.

Dr. Henry Parker Newman, the well known Chicago gynecologist, spent a few days recently with his friends in Los Angeles. There were so many former pupils and associates of Dr. Newman in Los Angeles that he seemed to feel as though he were at home.

Dr. L. T. Holland of Los Angeles died March 6, 1906. He was 63 years old, a graduate of the Missouri Medical College, and a post-graduate of the College of Physicians and Surgeons, New York. He had been practicing medicine in Los Angeles for twenty years.

Dr. F. T. Wright of Douglas, Arizona, is devoting himself to special work in the hospitals of Paris. He will attend the International Congress of Medicine at Lisbon on April 25th, after which he will resume his studies in Paris, returning to Arizona in September.

The Centennial Number of the *New York State Journal of Medicine*, Vol. VI, No. 3, contains the addresses delivered on the occasion of the one hundredth annual meeting of the New York State Medical Society held at Albany Jan. 30-31 and Feb. 1, 1906. It is a very valuable number.

Under the auspices of the Sken Monument Committee the unveiling of the Sken monument at the Prospect Park Plaza, Brooklyn, N. Y., took place on Saturday, May 5th. Dr. W. H. Snyder, of 26 Schermerhorn street, has been most active in the work of bringing this tribute to a fitting close.

The *Santa Paula Chronicle* announces that Dr. G. E. ApLynne of that city has the measles, and says his friends think it quite a joke on the genial doctor, "One thing sure—nobody else will have the measles in Santa Paula this year; there will be none left after the Doctor gets through."

The Lyman D. Morse Advertising Agency, which has been a well known factor in medical publicity for over fifty years, has moved to the Revillon Bldg., 19 W. Thirty-fourth street, New York City, where it has greatly enlarged facilities for handling its immense business. The name has been changed to the "Morse International Agency."

We have received the program of the third annual meeting of the Philippine Islands Medical Association, which was held in the library of the Bureau of Science, Manila, beginning February 28th. The program is beautifully gotten up, and the titles of the papers that were read give evidence of first-class quality.

The Orange County Medical Association at their meeting in Santa Ana on May 2nd elected the following officers: Dr. George H. Dobson, president; Dr. J. M. Burlew, vice-president; Dr. H. S. Gordon, secretary; Dr. C. D. Ball, Treasurer; Dr. F. M. Branner, librarian. After the election a banquet was greatly enjoyed. There were twenty-eight present.

Dr. O. D. Fitzgerald, one of the old-time physicians of Los Angeles, died in this city on April 28th. The Doctor has been one of the most faithful men in our medical societies, and in a quiet, unostentatious way has done a good general practice here. He was formerly the chief surgeon of the Santa Fe Railroad for the Pacific Coast. His life was respectable, honorable and creditable.

Dr. Harold Brunn and Miss Elsie Fecheimer, both from San Francisco, were married in San Bernardino on April 26. The homes of Dr. Brunn and his bride had each been destroyed, and Dr. Brunn's offices and equipment had been burned. The marriage took place, and Dr. Brunn came to Los Angeles and took the practice of Dr. J. DeBarth Shorb, who is spending six months abroad.

Beginning with this month *American Medicine* will be a monthly instead of a weekly. From the tone of an editorial in the journal it would seem that Dr. Gould feels that the *Journal of the American Medical Association* and the state journals are crowding out the independent journals. There are quite a number of physicians in Los Angeles who are stockholders in the American Medicine Publishing Co.

The Homeopathic physicians of Los Angeles have organized the Los Angeles Homeopathic Society. The following were elected as officers: W. J. Hawkes, president; Frank D. Bishop, Long Beach, first vice-president; N. G. Green, second vice-president; R. A. Campbell, secretary-treasurer; board of censors: Wm. L. Woodruff, H. T. Kerr, J. R. Newberry, T. C. Low and N. C. Clark.

Dr. W. Jarvis Barlow, as Chairman of the Committee of Physicians for collecting money from physicians for the San Francisco sufferers, reports a collection of \$2,050. When it is understood that every physician in Los Angeles gave through numerous other channels to the San Francisco relief fund, we think this showing is very good.

Dr. T. M. Michaels is a local surgeon for the El Paso and Southwestern Railroad at Torrance, New Mexico. This road is the connecting link for the Rock Island System owned by the Phelps-Dodge people, the great copper producers. Dr. Michaels is well known in Los Angeles, where he came in 1886. He has been in Torrance for the last four years.

*The American Society of Tropical Medicine*, containing papers read before the society and published under its auspices. Volume 1, 1904-1905, is the title of a volume we have just received. It contains important papers on Sanitation and Diseases of Panama and allied subjects. Any physician interested should

address Dr. Joseph McFarland, Secretary, Medico-Chirurgical College, Philadelphia.

The National Pharmacy Company have established temporary offices at No. 957 Broadway, Oakland. The fire completely destroyed their laboratory on the afternoon of Wednesday, April 18th. They have all of their working formula, together with a label and wrapper for every preparation that they manufacture, and they expect to be ready for business again within a few days.

Dr. Leonard Keehn, of St. Louis, died in Los Angeles on Monday, April 9th, of tuberculosis. He was married two months before his death to Mrs. Helen H. Preeman, of St. Louis. His father, Dr. August Keehn, lives at Castor, Mo. He has three brothers, Dr. G. A. Keehn, of St. Louis, Dr. Harry Keehn, of New Mexico, and Oscar Keehn, who is traveling abroad. In addition he leaves a sister, Mrs. Jas. Berry, of Castor, Mo.

The Seniors of the College of Medicine of the University of Southern California were the guests of the Juniors of that institution at a reception and dance given at Kramer's Hall on Wednesday evening, April 11th. The committee in charge of the arrangements consisted of: Leo A. Schroeder, C. E. Stanley, H. W. Wickett, P. O. Sundin, C. L. Lowman, Clifford A. Wright and P. B. Riggins. The hostesses were Dr. Elizabeth Follansbee, Dr. E. L. Leonard, Mrs. Claire W. Murphy and Mrs. J. Lee Hagadorn.

The Bishop of London, in a sermon before the under-graduates at Oxford, denounced college drinking, and declared that its prevalence was a disgrace to the intelligence of scholars. He said that in the west end of London a man who became drunk at dinner would never be invited again, and the professional man who was seen intoxi-

cated was greatly discounted among his better patrons.

Dr. Souttar, of London, a well known medical man, declares that the Bishop has in no way exaggerated the evil, and that the college becomes a practical school for the development of inebriety with mental and physical deterioration.

The death of Dr. C. H. Blaney, assistant superintendent of the County Hospital, on March 30th took from us one of our most promising and worthy young physicians. It is thought that Dr. Blaney's death was due to infection received while performing an autopsy about a year ago. He was thirty-one years old and had received the degree of A. B. from the Washington and Jefferson University, and the degree of M. D. from the College of Medicine of the University of Southern California. His grandfather was the first president of the Rush Medical College, Chicago. Dr. Henry Parker Newman of Chicago was with Dr. Blaney the day before his death and it was a great comfort to the young man to grasp the hand of a friend from his old home.

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In cases of malignant pustule, the infected area should be excised at once. Then inject strong solutions of bichloride of mercury (1 to 100 is recommended) into the vicinity of the pustule and apply bichloride solution constantly on cloths. Ipecac is used by some, applied locally and given internally in five grain doses every four hours. Vaughan advises the use of nucleinic acid.

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In the early months of pregnancy examinations should be made to determine that there is no retroversion or to treat it if it exists. A retroverted gravid uterus impacted in the curve of the sacrum always aborts.



**IN MEMORIUM.**

WHEREAS, Divine Providence has removed from our midst our fellow member, Dr. Charles F. Taggart, who suddenly lost his life while ministering to the needs of the sick and wounded in

THEREFORE, BE IT RESOLVED, That we tender to the bereaved family the heartfelt sympathy of this Society, and

BE IT FURTHER RESOLVED, That a copy of these resolutions be spread upon the minutes and a copy thereof be sent the



CHARLES F. TAGGART

San Francisco during the recent great disaster,

AND WHEREAS, This Society and the profession at large by his untimely death has lost an able surgeon and eminent physician whose life was filled with good deeds to suffering humanity; his family a kind and indulgent husband and father; and the community a valuable and patriotic citizen,

bereaved family, and to the SOUTHERN CALIFORNIA PRACTITIONER.

H. G. BRAINERD,

W. H. HITCHCOCK,

W. W. BECKETT,

Committee on Necrology for the  
Southern California Medical Society.

HOELL TYLER, *Pres.*

JOS. M. KING, *Secy.*

The *Los Angeles Times* of April 23d gave the following account of the death of Dr. Charles F. Taggart of Los Angeles, who gave up his life in San Francisco while engaged in the work of relieving the physical distress and suffering of the citizens of that unfortunate city:

"SAN FRANCISCO, April 22.—(Exclusive Dispatch.) Dr. Charles F. Taggart of Los Angeles was shot and instantly killed this forenoon by the accidental discharge of his own pistol. The tragedy occurred on the steps of the temporary hospital established in the Crocker grammar school on Page street near Baker street.

"Dr. Taggart was descending a stairway in company with the two other physicians, when for some reason he bent forward, and as he did so his pistol, an ammunition affair of latest make, dropped from his pocket to the ground. As it struck the ground the weapon was discharged and Dr. Taggart was seen to place his hand to his breast and stagger. His brother caught him, and as he held him the wounded man moaned: 'Oh, my God, I'm killed.' In another moment he was dead, the bullet had entered his heart.

"Tenderly they bore the body into the hospital and laid it upon one of the cots and covered it with a sheet. Later it was removed to a place at which it could be prepared for shipment to Los Angeles.

"Dr. Taggart came to San Francisco among the first of those who rushed to the aid of the sufferers here from the southern metropolis. He had charge of a corps of trained nurses and had been placed in charge of a temporary relief hospital a short distance from the limits of the burned district. Night and day he had been ministering to the sick and injured, for the hospital was filled with victims of the disaster which has befallen the city. For

days he did not remove his clothing, getting what sleep he could during the time that the other physicians relieved him. He did not complain, but worked hour after hour as long as his services were needed, and that was almost all the time.

"It frequently happened that calls came in from outside points asking that a physician be sent to care for some wounded person, and the condition of affairs in San Francisco is such in certain districts that it is not safe for a man to go unarmed. Dr. Taggart therefore carried his pistol with him.

"Dr. Taggart was a native of Palestine, Ill. He was born on Christmas day, 1860. He was educated in St. Louis and after being graduated by the St. Louis Medical College he came to California. Since 1895 he had been a resident of Los Angeles. He was prominent in Masonic circles, and in his profession was regarded as one of the leaders in this section of the State.

"The funeral services over the remains of Dr. Charles F. Taggart, who met death in such a tragic manner in San Francisco Sunday morning, were held at the family residence, No. 3316 South Grand avenue, Wednesday afternoon. The services which were conducted by Rev. Frank DeWitt Talmage, were brief and impressive.

"There were many beautiful floral designs and set pieces. The Jonathan Club sent two handsome pieces, as did the local society of physicians. A large symbolic emblem was from the Shriners, of which Dr. Taggart was a prominent member. A beautiful star of white carnations was from Pacific Chapter, Order of the Eastern Star. All who knew Dr. Taggart loved him as a true friend and kind physician.

"The florists announced that all moneys received by them for the floral designs would be sent to the San Francisco sufferers. The remains of

Dr. Taggart were taken to Rosedale Cemetery and placed in a vault to await the arrival of Mrs. Taggart's sister, who is hastening from St. Louis. The active pall-bearers were Dr. J. D. Van Vleck, Willard Stimson, Dr. George L. Cole, Dr. W. W. Hitchcock, Dr. G. A. Scroggs

and P. V. Collins. The honorary pall-bearers were Dr. George W. Lasher, Dr. Walter Lindley, Dr. A. C. Hanna, Dr. Joseph Kurtz, Dr. A. C. Rogers, Dr. M. L. Moore, Dr. D. K. Dickinson, E. W. Gillett, Willis Hunt and J. F. Culien."

## DEPARTMENTAL

### DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M.D., EDITOR.

**HYSTERECTOMY IN ADVANCED CANCER.**—Prof. Wertheim of Vienna made a deep impression by a recent paper read before the Section of Obstetrics and Gynecology of the British Medical Association. His subject was the Diagnosis and Treatment of Cancer of the Uterus, and without wishing to interfere with the ordinary mode of dealing with cancer of the cervix alone or cancer of the body alone, Prof. Wertheim proceeded to show that operative interference was not out of the question even when the growth had spread from the uterus to adjoining parts. Vaginal hysterectomy is the favorite operation in this country and it is generally held that when the uterus is fixed by extension of the growth from it to neighboring structures, it is not advisable to attempt removal, as no security can be obtained that the limits of the disease have been reached. Moreover, the technical difficulties are very great in such cases. But Prof. Wertheim approaches the disease in these instances by the abdominal route, and by the perfection of technique to which he has attained, can remove the whole of the diseased parts with a flattering mortality result. In a consecutive series of 270 such cases, he has experienced a fatality rate of only 15 to 18 per cent. for several years, whilst of the last 30 of the series he has lost but two—a result as regards the latter

figures that does not compare unfavorably with the average operator's results for ordinary hysterectomy. The crux of the value of such feats of surgical gymnastics, however, resides in the ultimate freedom of patients from recurrence of the disease, and here Prof. Wertheim more than justifies his contentions. In 60 to 70 per cent. of his cases no recurrence has taken place in periods varying from four to five years after operation. Prof. Wertheim was warmly congratulated on his triumphs.—*Medical Note and Queries*, Nov. 1905, p. 148.

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**THE TREATMENT OF ACUTE ANTERIOR POLIOMYELITIS BY NERVE TRANSPLANTATION.**—The authors consider the pathology of the disease and state that in a limb with paralysis of but few muscles, union of healthy nerve cells in the anterior half of the cord, with the fibres supplying the affected muscles, can be effected by nerve transplantation. They performed this operation on a child who had a paralyzed tibialis anticus muscle for two years. The peroneal nerve was exposed and the branch to the tibialis anticus was sutured into the musculocutaneous nerve. A year and a half after operation recovery is almost complete. Dr. Frazier performed a similar operation on another case but did not obtain as good a result.—Spiller, W. G.,



and Frazier, C. H.: *Journal of the American Medical Association*, January 21, 1905, p. 169, and *Archiv Ped.*, January, 1906.

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**POLYCYTHEMIA AND ICTERUS NEONATORUM.**—The author discusses the vexed origin of icterus in the new-born. Is it hepatogenic or hematogenic? Our author's convictions are thus formulated. During the first five to six days after birth there is a condition of hyperglobulia in the blood, as a result of plethora, due to the passage of placental blood into the infant's circulation. This hyperglobulia or polycythemia is transient and pathological. The excess of blood in the child's circulation is rapidly carried off, the fluid portion leaving the system through the kidneys. And as the fluid surplus is eliminated a thickened state of the blood remains, which is remedied by a destruction of red cells. If this destruction goes on very rapidly, icterus is the consequence. Hence the jaundice of the newborn is hematogenic in origin, due to plethora and hyperglobulia. The self-evident prophylactic measure consists in early ligation of the cord.—*Chuprin, Medizin. Obosren.*, lxi., No. 17, p. 311, and *Arch. Ped.*, Jan., 1906.

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**ACUTE GONOCOCCIC PELVIC PERITONITIS IN CHILDREN.**—Mauclair relates in *La Clinique Infant*, May, 1905, a case in a girl aged 15 years, admitted with an acute vulvovaginitis, who was seized six days later with severe abdominal pain, constipation and vomiting, the temperature rising to 41.2° C., pulse 130. The day following, on the question of laparotomy arising, some improvement was noticed which continued, and recovery ensued three weeks later. The author considers it necessary to distinguish between *pelvi-peritonitis*, *sub-umbilical*, and *general peritonitis*. The pain being diffuse in this case proved that it

was not one of simple salpingitis; the absence of umbilical and sub-umbilical pain showed that the infection and peritoneal reaction were limited to the pelvis. Treatment is an interesting point; many observers (Variot, Comby, Broca, etc.) are partisans of non-intervention surgically, since gonococcic peritonitis has an abrupt onset, grave general symptoms, but early, unexpected and definite amelioration. The treatment should thus be "exclusively medical." The author, however, thinks that this only applies to slight cases; where there exists alarming symptoms surgical treatment is indicated, for recorded cases show that the infection is not purely gonococcal, staphylococci and streptococci being also present, while a study of fatal cases leads him to the opinion that one should intervene if the situation is threatening and not wait until it is compromised; if laparotomy is followed by death it is because it was done too late. Of the seven cases operated on, five recovered; of the eight fatal cases, only two were operated on. The author thinks that these cases are often confused with appendical peritonitis and operated on as such.—*British Journal of Children's Diseases*, London, Dec., 1905.

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**A METHOD OF STERILIZING SPONGES.**—As the marine sponge is superior in its absorbing power to any of its substitutes, F. W. Andrews of London has long sought a method which would insure its sterility. To prepare such a disinfecting solution, 37 grammes of ammonium persulphate,  $(\text{NH}_4)_2\text{S}_2\text{O}_8$ , are dissolved in 950 cubic centimeters of distilled water, and 11 cubic centimeters of strong hydrochloric acid are then added. The mixture when first made up has no extraordinary germicidal powers and must be allowed to stand for several days before using, when it will then appear

as a perfectly clear solution and remain efficient for many weeks. Like formaldehyde, it may fix bloodstains in the crevices of the nails, and in a few cases may roughen the hands or give rise to eczema if its use be long continued. The sponges are first thoroughly cleansed and become sterilized within an hour after being placed in the mixture. Moreover, discolored sponges are bleached and renovated; a sojourn of two or three days in the mixture being requisite for this purpose. For use the sponge should be stored in a carbolic acid solution. In order to show the safety of this method, an old sponge which had been discarded because it had been discolored was obtained from the operating theater. It was then taken to the post-mortem room and soaked in blood and faeces for a night. The next morning a quantity of sewerage in a highly offensive condition

was poured over the sponge. Lastly an emulsion of hay-bacillus spores was added. The sponge was then cleansed mechanically under a hot-water tap, and scrubbed two or three times in succession in soap. After five minutes it appeared clean, was squeezed once or twice, and perfectly covered with the persulphate mixture for an hour. Pieces cut off from the sponge and placed in sterilized broth were found to be sterile for four days' incubation at blood heat. The only fallacy in the experiment would seem to be in the fact that sufficient of the persulphate to prevent the growth of the organisms might have been removed with the sponge. In order to avoid this the broth was changed after the sponge had been permitted to remain in it for several hours. —*Lancet*, October 14, 1905. *Medical Notes and Queries*, Vol. I, No. 9, Nov., 1905, p. 138.

## DEPARTMENT OF INTERNAL MEDICINE.

CONDUCTED BY DUDLEY FULTON, M.D., LOS ANGELES.

**A NEW METHOD OF TESTING THE FUNCTIONS OF THE DIGESTIVE APPARATUS.**—Max Einhorn tests the digestive powers of both the stomach and the intestines, by attaching solid food stuffs to glass or porcelaine beads (by drawing them through the opening in the bead and tying them on with a silk thread) and then to have them pass through the stomach and bowels in order to see finally what remained attached to the bead. Substances which have been digested will have disappeared, while indigestible articles will be found in the faeces attached to the bead.

To test the work of the stomach alone, the beads with the food attached are tied to a long silk thread and swallowed and exposed to the action of the

gastric juice for the desired time, when they are withdrawn and carefully examined.

Einhorn has experimented, using this method, with various food substances and in different digestive disorders, and believes that it gives deep insight into the functions of the digestive tract. —*Med. Record*. Feb. 10, 1906.

**SERUM THERAPY IN ERYSIPELAS.**—Ayer (*Med. Record*, No. 1816, 1905) gives the following opinion after using the above treatment in 33 cases, all of which were treated with serum on or before the third day, as the author believes the treatment to be futile if used later in the disease: The average duration after treatment was 6.8 days. The initial leukocytosis was high, falling to normal on the day of desquama-

tion. Albuminuria was present in 40 per cent. of the cases, but in over half of these disappeared by the second day of treatment. Thirty-two of the cases were of the facial type, and in comparing these cases and 15 others previously reported with 79 cases treated by older methods, the author concludes that the shortening of the course of the disease by 2.6 days expressed the value of the serum treatment. The general amelioration of all the subjective symptoms is also in its favor.

INDICATIONS FOR THE USE OF STROPHANTHUS.—According to Osborne the indications for preferring strophanthus to digitalis are: (1) When there is need of a cardiac tonic, and digitalis produces nausea, vomiting and too great an increase in the blood pressure; (2) When a cardiac tonic is indicated and the blood pressure is already high; (3) When a rapidly acting heart tonic is needed; (4) When there is more irritability and weakness of the heart, than muscular debility or incompetency; (5) Children are very susceptible to the action of digitalis, hence, strophanthus is many times a better drug for them when a cardiac tonic is indicated.—*Therapeutic Gazette*.

IS SYPHILIS OR MERCURY RESPONSIBLE IN THE ETIOLOGY OF PARESIS AND LOCOMOTOR ATAXIA?—Wolter, in the "*Courier of Medicine*," Vol. 34, No. 2, presents a thoughtful study of the above subject. Judging from the literature, the dictum given by Ferrier years ago: "No syphilis, no tabes," is not true, for, it is by no means uncommon in this disease to be absolutely unable to find syphilis as an etiological factor.

Wolter considers the following points:

1. Syphilis is rife among negroes; tabes and paresis are rare.

2. The branny individual is the usual victim. Brains are usually associated with wealth, and brains and wealth are the requisites in obtaining prolonged anti-syphilitic treatment. The negro is saturated with syphilis but he escapes prolonged exposure to mercury.

3. The pathology of the above diseases does not compare with the pathology of primary, secondary or tertiary syphilis.

4. Mercury is a most diffusible element. It permeates all the tissues. As a foreign substance it is followed by tissue reaction, irritation and finally inflammation, and implantation of interstitial tissue, which is the dominant feature in the pathology of paresis and tabes.

5. Anti-syphilitic treatment does harm in paresis and tabes. In the few cases which are improved by syphilitic medication, Wolter considers them to be those clouded cases of syphilis of the nervous system.

6. That paresis and tabes are syphilitic in a large percentage of cases is admitted by Wolter, but he also claims that it is equally true that they are mercurialized.

THE PRESENT STATUS OF BLOOD CYROSCOPY IN DETERMINING THE FUNCTIONAL ACTIVITY OF THE KIDNEYS.—Beer, in discussing the above question (*Amer. Jour. Med. Sciences*, Feb. 1906), briefly reviews this new method of determining the work accomplished by the kidneys and the results obtained thereby.

The method consists in determining the molecular concentration of the blood by means of freezing it. Normally the blood freezes at -56 degrees C. If the blood is more or less concentrated the freezing point will be respectively higher or lower. The kidneys seem to be the most important



regulators of the concentration of the blood, and in general the freezing point of blood ranges from  $-55^{\circ}\text{C}$  to  $-57^{\circ}\text{C}$ . when the kidneys are working normally.

Kummell and others are enthusiastic in the application of this principle in clinical work. They affirm, "if the blood freezes at  $-56^{\circ}\text{C}$ . there is no general disturbance of renal function—whereas increased concentration regularly denotes a bilateral kidney disease."

Beer in experimental work and in a review of the literature gives the following present status of the method:

1. "Cryoscopic data, like quantitative analyses of the urine, tell us in a measure what is happening at the moment and nothing more. The compensatory powers of the kidney are far from the cryoscopist's observational powers, and probably they will never reveal themselves."

2. The kidneys, though the most important organs in regulating the molecular concentration and osmotic pressure of the blood, are not the only organs concerned with this intricate process.

3. An anatomically normal organ (kidney) may be so disturbed in its functional activity as to appear seriously diseased, being temporarily incapable of excreting its quota of molecules.

4. The concentration of the blood may be normal, even though the kidneys are badly diseased. Cryoscopy of the blood as yet, gives us but little absolutely accurate information as to the present activity of the kidneys; much less, naturally, does it tell us about the outlook, as it is in no wise capable of measuring the compensatory hypertrophy, which may develop in any kidney.

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**CHRONIC AND PERIODIC VOMITING.**—To make a diagnosis of the causation in chronic vomiting necessi-

tates a careful search of the entire body and its functions. Roberts (*Med. Record*, Feb. 24, 1906) offers the following helpful suggestions:

1. Vomiting of a chronic type, following a gradually developed epigastria, one-half to three hours after meals, is attributable to peptic ulcer, gastric and duodenal.

2. Chronic vomiting that occurs ten or fifteen minutes after food ingestion is attributable to stenosis of the cardia, nervous abnormality, cerebral lesion, or to protracted gastritis.

3. Copious vomiting ten or more hours after eating indicates a permanent lesion in the nature of a mechanical interference with the exit of food.

4. Vomiting in the night is particularly liable to occur in cholelithiasis, periodic hypersecretion, muscular insufficiency, and nervous abnormality—vomiting when the stomach is empty, indicates a cause other than a gastric lesion, either a reflex, a toxemia, a cerebral lesion or a nervous abnormality.

5. Morning nausea and retching indicate either a beginning of pregnancy, alcoholism, pharyngitis, nephritis, or a nervous abnormality.

6. Periodic vomiting of clear gastric juice of normal or supernormal acidity in any considerable amounts indicates a secretory neurosis or an ulcerative lesion.

7. Vomiting as a sequel of headache, accompanied by severe nausea but no gastric or abdominal symptoms, characterizes attacks of migraine; in a majority of cases eyestrain is the underlying cause.

8. Attacks of vomiting of sudden onset, with tinnitus, deafness, and vertigo, are attributable to disturbances of pressure in the middle or internal ear.

9. Periodic attacks of vomiting of sudden onset, associated with more or less of gastric pain and nausea, retraction of the abdomen, obstinate constipation during but not preceding the attack, and

freedom from abdominal tenderness, are associated with spinal crisis, idiopathic nervous vomiting, and lead poisoning.

10. Periodic attacks of vomiting after

abdominal colic and constipation, with localized or general tympanitis, are suggestive of chronic intestinal stenosis.

## SOCIETY TRANSACTIONS.

### LOS ANGELES COUNTY MEDICAL ASSOCIATION.

MEETING OF APRIL 6, 1906.

#### CLINICAL MEETING.

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DR. STANLEY BLACK:—Presented several specimens of stomach and intestinal tract, showing the lesions of the lymphoid tissue in the *Status Lymphaticus*. Stated the condition was one that was worthy of a wider knowledge.

Specimen I. Man was given to fainting. Up to a few minutes before death was in good health. These fainting spells had been present since age of fourteen. Went to telephone, called out that he was dying. Nothing abnormal on exterior of body except a bruise on the right index finger. Post-mortem showed normal heart, except right heart dilated. Follicles of gastro-intestinal tract, from tongue through small intestines enlarged. Not so prominent in large intestine. Spleen enlarged.

Speaker referred to several cases he had seen in Vienna with Kolisko, the medico-legal examiner. Also to child of Langhan's of Berlin, which had supposedly died of diphtheria anti-toxin injection, but in which *Status Lymphaticus* was found to be present.

Specimen II. Specimen was obtained from body of a young man of 20, who had gone to bed in good health, but who was found dead during the night.

Replying to a question Dr. Black stated that if adenoids were present in a patient about to take anaesthesia, he would avoid cocaine and chloroform

of Bone had been Removed. The case history was as follows:

Mrs. M. J. P., age 56, widow, three children. Family history good. No specific history. Saw patient first on August 12, 1903. Severe frontal headache. Recovery after use of caltars. Saw her off and on in his office until latter part of October. She had muco-purulent nasal discharge, with frontal headache at times. Removed polypus from nose and treated rhinitis with nasal sprays. Suspected sinus trouble, but patient passed from under his care and did not see her again until November 23, 1904. She then had two open sinuses, one each side of the forehead, discharging a foul smelling pus. Constant foul nasal discharge. Sputum nearly gone. Operated three days later. Found vertical portion frontal bone dead, with pus oozing from underneath. Opened frontal sinus through to nose and drained. Anti-septic dressing. At a secondary dressing about one month later, removed vertical portion frontal bone, cleansed and dressed with normal salt solution. From that time on for about eight months the wound required constant attention, dressings, skin grafting, etc. The patient has been on K. I. most of the time since first operation. There is still some nasal discharge and probably always will be. The wound has been well for about six or eight months, with no brain symptoms whatever.

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DR. M. L. LEOMIS:—Presented a patient from whose Skull a Large Amount

DR. THEODORE DAVIS:—Presented a specimen of a *Ruptured Heart*. Patient was seen about a year ago. Had pre-

cordial pains, of increasing severity. Heart action became very irregular. Died suddenly, and postmortem the rent in the left ventricle was found. Heart was fatty and large and vessel showed atheromatous patches.

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DR. H. H. SHERK:—Gave case history of patient who died from *Rupture of Lower Part of Thoracic Aorta*. Man was taken suddenly ill with intense pain under ribs on the right side. When seen by speaker, he was sitting upon edge of bed, supported by a friend. Pulse 60 and of fair quality. Respirations rapid. Subnormal temperature. Rigidity of abdominal muscles. Leucocytosis of 16,000. Later nausea and more rigidity of abdominal muscles. Sent him to hospital, but ten minutes later he was dead. Good pulse had led speaker to lean to diagnosis of perforation of stomach rather than ruptured aneurism. Postmortem the rupture, about one inch long, was found to have originated in an atheromatous ulcer near the diaphragm.

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DR. FITCH MATTISON:—Gave case history of man with *Ruptured Aneurism* into trachea.

\* \* \*

DR. J. O. COBB:—Referred to a sailor, who in doing some heavy lifting became nauseated. Several months later Dr. Cobb saw the man, who complained of pain on right side and showed slight jaundice. Treated for catarrhal jaundice. Complained of pain when he was on his feet. Changed diagnosis later to suppurative gall bladder, but exploratory laparotomy showed gall bladder normal. Post-mortem a small *Rupture of Descending Aorta* was found.

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DR. H. H. SHERK:—Presented specimen of *Extra-uterine Pregnancy*. Patient had had an extra-uterine pregnancy seven years before, for which she had been operated on in the East. This time she had missed one period and suffered

from abdominal pain. Later she collapsed. Operation revealed specimen presented.

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DR. G. G. SPEER:—Reported a patient who had bruised his foot, two ulcers resulting. Diphtheretic like membrane, one edge healing while the other edge broke down. Very resistant to treatment.

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DR. E. L. LEONARD:—Reported two cases of amoebic dysentery, one case of a soldier and the other of a Japanese.

#### MEETING OF APRIL 13, 1906.

This meeting was given over to a *Symposium on Hip-Joint Disease*, arranged by Dr. P. C. Pahl.

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DR. EDWIN WILEY read a paper on the *Etiology and Pathology of Hip-Joint Disease*.

Hip disease, known by a large number of synonyms, was a term especially applied to tubercular joint disease affecting the hip. The more sluggish circulation in the joints of the lower extremity favored the disease. The right side being used more than the left, there was a slight difference in its favor. The exciting cause is the bacillus of tuberculosis. Among predisposing conditions are included the following. Age—the disease is one essentially of childhood; sex—more males; heredity—tuberculous ancestry predisposes; traumatism—falls upon the trochanter and feet predispose; debility—especially following the exanthematous diseases.

The joint may be involved, one, by way of the circulation or two, by direct extension of the process from infected neighboring structures. Hip disease is usually secondary to a tuberculous focus elsewhere in the body, the most common modes of entry being through the respiratory and intestinal tracts.

The localization of the process is



determined by the vascular twig through which the bacillary embolus is propelled. The synovial membrane is attacked primarily in 16 per cent. There are two synovial pathological types, one, a mild cloudy effusion and two, the more common form, with profuse and caseating granulations. An osseous lesion may be intra or extra-articular. The location of the more frequent foci of this class of cases was given, with the pathology and course of the disease.

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DR. P. C. H. PAHL presented a paper on the *Symptoms and Diagnosis of Hip-Joint Disease*.

There were four varieties of hip disease in the infant—tubercular, gonorrheal, syphilitic or pseudo-paralytic and inflammatory.

In the gonorrheal form, the symptoms are very acute, with pain, swelling, restricted motion and malposition present.

In the syphilitic type, there is well-marked swelling, some pain and interference with motion but no rigidity.

Streptococcic and bacterium colic infection are similar in symptomatology to the gonorrheal form, although of a somewhat less acute type.

The tubercular hip-joint disease occurs almost entirely in walking children. The symptoms are often obscure and mistaken for growing pains, rheumatism, knee-joint disease, or even a poorly fitting shoe. They consist of lameness, pain, induration about the joint, limitation of motion and slight general constitutional derangement. As the case becomes somewhat advanced, there is an apparent lengthening of the limb, muscular atrophy and frequently night cries. The child guards the foot of the affected side with the well one, and cries when anyone attempts to move it. The further course of the disease was then outlined and the positions necessary to place the patient in, in taking measurements of the limbs

and the technique of making these measurements were given in detail.

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DR. JOSEPH KURTZ considered the *Mechanical Treatment of Hip-Joint Disease*.

The remedy *par excellence* for hip-joint disease was rest and rest could only be obtained by mechanical treatment. It was interesting in this connection to note how each orthopaedist imagined that his specially modified apparatus was superior to all other forms. The truth is this, that in the hands of competent men, most of the forms of apparatus in common use will give excellent results. A good mechanical apparatus for hip-joint disease, while it should subserve rest of the limb should however, not interfere with the outdoor life. The apparatus was to immobilize the joint and relieve it of the body weight.

Mechanical apparatus falls into two main classes: one, those types which procure immobilization only, and two, those forms which give immobilization with traction.

It is the second class that is generally used in America, while in Europe the first type is much used. While the essayist regarded the second type as excellent, he felt there were drawbacks connected therewith.

Among the American splints are the Taylor's, the Judd's, the Sayre's, the Lovett's, the Phelps', the Bradford, each of which has its good points and each of which may do good service.

Of the European splints, would mention the plaster of Paris, the Lorenz brace, the Thomas.

The plaster of Paris is certainly excellent and the world owes more to L. Sayre for the introduction of the plaster jackets or hip-dressings than for almost anything else he accomplished.

The essayist himself, employed a modification of the Thomas more than any other. Had made a modification of his own for a poor patient and found it so excellent, adopted it for other cases.

Intended to show it as "his own," but two days ago, a child entered his office with precisely the same splint that had been applied, he thought, by Dr. Gibney of the Hospital for Crippled Children in Brooklyn. In treating early cases of tubercular hip disease, bed rest and extension with weight and pulley will give excellent results. After a month of such treatment he resorted to either a plaster jacket or his modification of the Thomas splint.

In more advanced cases, the question for immediate or gradual correction of the deformity arose.

The details of the treatment of such cases were then elaborated.

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DR. W. LEMOYNE WILLS read a paper on the *Operative Treatment of Hip-Joint Disease*, in the chronic and complication stages.

Abscess was a complication in about 50 per cent. of all cases. Early treatment reduces these figures to 20 per cent. A common seat for abscess sinus was on the upper and anterior part of the thigh, external to the femoral vessels. Long standing suppuration may be attended by emaciation, amyloid changes and death. Pus once diagnosed, it was to be aspirated or evacuated by incision. Old sinuses were to be opened up and curetted.

A sharply defined focus, even with skiagram, was not easy to obtain. If a well defined focus be present, it was to be exposed with care, and after having been scraped, was to be dried and wiped out with pure carbolic acid and alcohol, or two and one-half per cent. solution of formalin, and the wound closed all but temporary gauze wick.

In a particularly complete ankylosis with leg at bad angle to trunk, correction by osteotomy as devised by Gant, lessens the deformity in locomotion and gives greater length to the leg. The technique of the operation was described, likewise Mr. Robert Jones' modification thereof.

Excision of the hip-joint is not justified in early cases. Its utility and advisability has given rise to much controversy. The best rule seems that if the patient can have all the care and attention necessary, for a long period of time, then the conservative plan of non-excision seemed to be preferable. But with poor patients, who must get up and about as soon as possible, the radical method of excision was abundantly justified. Statistics in regard to this operation varied much with the class of patients as well as with hospital surroundings and operators' mode of technique.

Operation by posterior incision over the middle of the great trochanter, freely exposing capsule and upper end of femur may be done.

In regard to amputation, if done early, results are superior to excision, from standpoint of general improvement and mortality. The deformity drawback may be remedied by mechanical devices.

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#### DISCUSSION OF SYMPOSIUM ON HIP-JOINT DISEASE.

DR. GEO. W. LASHER:—Referring to the etiology, stated that the bacillus of tuberculosis was responsible for the most frequent type of the disease. The pathological unit was the same as in other forms of tubercular inflammation.

As to mortality from the disease, in his own experience, remembered only two or three deaths. Thinks low mortality here due more to climate than to skill of surgeons. Southern California climate was splendidly adapted to the treatment of the disease and children actually grew fat lying in bed. Speaker believed many cases to be of primary nature as regards source of infection. In hip, the zone of election for the pathologic process was the line between diaphysis and epiphysis and tendency in tuberculosis of hip joint was for extension toward the epiphysis, while in osteomyelitis it was toward the shaft.

In the early stages symptoms were often obscure. Inquire always why a child has a voluntary limp. Early treatment means good prognosis. If diagnosis not certain immobilization for a time could do no harm. Too many cases are diagnosed as mono-articular rheumatism. Immobilization is the treatment indicated and if practiced early may result in cure in less than two years. Discussed the

special splints and apparatus and treatment advanced by Doctors Kurtz and Wills.

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DR. P. C. PAHL:—Hygienic treatment was always a matter of the first importance in this disease. Was much interested in Dr. Kurtz's splints. For himself preferred plaster of Paris and short Lorenz spica. Put patient on crutches, forced feeding somewhat and kept him out of doors. Regarding anaesthesia, preferred in, to repair deformity. Cast could then be applied and after a week in bed was able to go out of doors. Patients that are up and around do better.

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DR. JOSEPH KURTZ:—Referring to Dr. Lasher's point about trephining the neck of the femur, stated that if we can absolutely locate the focus of the disease, we may succeed. Preferred a mixture of Iodoform and olive oil to fill in the cavity.

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DR. LE MOYNE WILLS:—Referred to papers read and then demonstrated a Jones' saw which he had brought back from Europe.

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DR. FITCH MATTISON:—Complimented speakers on their excellent papers. Was glad to note the kind words about Southern California's excellent climate and desired especially, in that connection, to call attention to the advantages of Pasadena's climate.

#### NO MEETINGS ON APRIL 20, 27, AND MAY 4, 1906.

NOTE:—Owing to the meeting of the Medical Society of the State of California during the week of April 15th, the death of Dr. Charles F. Taggart of Los Angeles, during the following week, and the meeting of the Southern California Medical Society during the week of May 1st, meetings of the Los Angeles County Medical Association were not called for those weeks.

#### MEETING OF MAY 11, 1906.

This was a meeting of the Eye, Ear, Nose and Throat Section of the Los Angeles County Medical Association, to which the members of the County Association at large were specially invited.

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DR. FITCH MATTISON, President of the County Medical Association, called the meeting to order and stated its object.

DR. H. BERT ELLIS spoke on the losses sustained by the members of our pro-

fession in San Francisco and moved that a committee of seven be appointed to raise funds for the relief of members of the State Medical Society, who were in need. This motion was unanimously carried. The work of this committee is considered in one of the editorials of this issue of the PRACTITIONER.

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Dr. Mattison then turned the meeting over to DR. W. W. MURPHY, Chairman of the Eye, Ear, Nose and Throat Section, who stated that the subject of the evening was a "*Symposium on Mastoiditis*" and that it was the desire of the Section to direct attention to the subject, not only because of its importance to specialists but because the disease, as a rule, was met with in its first or curable stages by general practitioners, and that it was therefore a matter of extreme importance that the serious nature of the condition be recognized at this time.

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The first essayist of the evening was DR. HILL HASTINGS, who considered the "*Etiology and Abortive Treatment of Mastoiditis*."

He stated that about ninety per cent of all cases of Mastoiditis follow ordinary colds in the head. Abortive treatment of Mastoiditis in the great majority of instances, therefore, had to do with the treatment of such colds. The embryology and anatomy of the middle ear in its relation to the pharyngeal mucosa and the extension of inflammation along the Eustachian tube, were discussed and the poor drainage capacity of the Eustachian tube considered. Attention was called to the thin bony partition separating the middle ear from the cranial cavity, thus permitting dangerous intracranial complications. Suppurative Otitis Media was more dangerous than inflammation of any accessory sinus of the nose.

As to abortive treatment of colds in the head, local cleanliness by bland saline solution and cocaine and adrena-



lin for swelling of Eustachian membrane, followed by ten per cent. silver nitrate were suggested. A camphor-menthol solution for naso-pharynx. Rest and internal medication. For stuffiness of the ear, inflation of Eustachian tube recommended. As spontaneous rupture of drum membrane was nearly always insufficient for drainage, full and early incision was recommended when local symptoms increased. Syringe ear every two hours after incision and dry properly. Local applications, as ice and leeches, were also discussed.

Several anatomical models and specimens were presented which brought out the anatomical relations previously considered.

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DR. R. W. MILLER read a paper on "*Symptoms and Physical Signs of Mastoiditis.*"

There was one symptom that was always present in Mastoiditis, viz.: pain, which varied, however, in character. For instance, was more at night, especially so in children. Was to be differentiated from neuralgia of the mastoid region. Diminution of pain and improvement of general symptoms not to be taken as an invariable sign of improvement. Tenderness on deep pressure, tumefaction, oedema, fluctuation, discharge, pulse and temperature were other symptoms and signs discussed.

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DR. ROSS MOORE discussed "*Meningitis as a Complication of Mastoiditis.*"

Meningitis was an important complication since it preceded brain abscess in so many instances. One-third of all brain abscesses had their origin in middle ear inflammation. The symptoms were then considered in detail.

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DR. FRANCIS KELLOG: Reported case of a child of six; saw patient first time with discharging ear through lower segment left membrana tympani. An attack a year previous at which time adenoids had been removed. These

having recurred they were again removed. Perforation persisted and six months later polyp was still protruding therefrom and this was snipped off. About six months later child had a moderate ear ache and slight bulging membrane. Temperature remained 101 to 103 degrees, for about five days. Extreme prostration. No tenderness on pressure over mastoid until fifth day. On that day child was taken to the hospital and operated upon. Free incision brought forth only a very scanty discharge. No pus in mastoid cells. Temperature next day 99 degrees and child asked for its dolls. The following day temperature was 102 degrees, and at seven o'clock child was semi-comatose. Wound was healthy. Cheyne-Stokes respiration came on, and child died that evening. Suppuration had probably extended to brain through brain and nerve sheaths, and induced a lepto-meningitis.

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DR. H. BERT ELLIS read a paper on "*Sinus Thrombosis in Mastoiditis.*"

The anatomical relations of the middle ear favored this complication, which was more frequent than brain abscess complication. Therapeutically the condition was to be attacked by way of the mastoid. Symptoms were insidious. Temperature might rise suddenly and then drop. Temperature was to be taken frequently in middle ear trouble. A severe chill while often present, could be absent. Swelling also could be absent. Mental dullness, convulsions, tenderness on pressure, swelling of lymphatics behind the jaws, eye signs, were other symptoms considered.

In operation all infected bone was first to be removed and sinus to healthy portions was to be exposed. The technique of the operation was then described in detail.

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DR. W. D. BABCOCK: Reported three cases of "*Sinus Thrombosis,*" two with recovery and one fatal.

Case 1. Negro, age 65, in whom

sinus was opened, clot removed and good recovery made.

Case 2. Fireman, who had had a paracentesis done, but returning to work, and inflammation recurring, operation was done and sinus thrombus was removed and man is now at work.

Case 3. Woman, with advanced inflammation. Here extensive area involved, made recovery impossible.

\* \* \*

DR. A. L. KELSEY: Reported a case of "*Sinus Thrombosis*" seen with Dr. T. J. McCoy.

Primary operation was done on patient but patient's son refused secondary operation and man died. Post-mortem revealed sinus thrombosed and tentorium covered with exudate and a cerebellar abscess size of a walnut present. Case suggested importance of investigating condition of sinus at time of primary operation.

\* \* \*

DR. E. O. PALMER: Reported a case of "*Sinus Thrombosis*" seen by him in general practice and referred to Dr. H. Bert Ellis.

Patient was a young woman of 23, history of mild ear trouble of several years duration, in whom no mastoid symptoms were present for several days. In the operation which promptly followed sinus was found thrombosed, and clot was cleared out. Good recovery and patient is now at work. Here was a case with serious complication but no symptoms to indicate its presence.

\* \* \*

DR. J. J. FISHER considered "*Brain Abscess as a Complication in Mastoiditis*."

Diagnosis was often very difficult. Recalled a case seen in Kraft-Ebbing's Clinic, which that master had wrongly diagnosed. Route followed by pus discussed. Radical operative measures were advised for this complication.

\* \* \*

DR. H. G. BRAINERD gave a talk on

"*Brain Abscess Complication in Mastoiditis*."

No intra-cranial lesions were more unsatisfactory to diagnose than Brain Abscess complications of Mastoiditis. There were no such things as typical symptoms and oftentimes such symptoms as were present were obscured by others due to sinus thrombosis or meningitis.

Abscesses in brain substance might be single or multiple. McEwan's rule was that an abscess dependent on extension from a mastoiditis was usually below the tentorium. On the localization of the abscess would depend many of the symptoms in any particular case.

Headache, pain, tenderness, disturbance of intellect, temperature, pulse, condition of retina, anaesthesias, parasthesias, aphasias, disturbances of equilibrium were some of the points discussed. Cited a case seen in consultation with Dr. H. Bert Ellis which especially showed the shifting temperature range.

\* \* \*

DR. F. W. MILLER discussed the "*Indications for Operation in Mastoiditis*," and among others suggested operation—

When empyema or necrosis of mastoid cells was established.

When there was external evidence of periostitis.

Where abortive measures were not successful within forty-eight hours.

When a profuse discharge suddenly ceased.

When drainage was insufficient.

When mastoid tenderness continued after incision.

When sepsis showed itself.

When in doubt an exploration was to be made. He did not lay much stress on value of the temperature or on results of bacteriologic examination.

\* \* \*

DR. E. W. FLEMING discussed in detail the "*Surgical Treatment of Mastoiditis*," stating that in the technique suggested nothing especially different from the usual description given in the

books on these operations, was advocated.

\* \* \*

DR. B. F. CHURCH considered the "*Surgical Treatment of the Complications of Mastoiditis*," reviewing such complications as sinus thrombosis and abscess and illustrating his talk on operative methods by some excellent drawings thrown on a screen by a stereopticon.

\* \* \*

#### DISCUSSION OF THE SYMPOSIUM ON MASTOIDITIS.

DR. E. W. FLEMING: As illustrating the difficulties met with in Mastoiditis, read the following letter, written to the home physician of one of his patients:

Los Angeles, Cal., May 4, 1906.

Dear Doctor:

As one of the late physicians of Mr. X, Dr. Walter Lindley, Medical Director of the California Hospital, has requested me to reply to your recent letter to him asking for information in regard to the case.

I first saw Mr. X. January 18th, 1906. He came to me on account of ear trouble, which he contracted while traveling a few days, perhaps a week before, and on examination I found that he had acute suppurative inflammation of the left middle ear.

Prompt incision of the drum head was followed by a profuse discharge of pus and relief of pain. Upon my advice he went to the hospital and remained there during the following two weeks, receiving the usual treatment incident to such cases. He now made daily visits to my office. Four weeks from the time I first saw him I advised that he submit to a Mastoid operation—not because of signs or symptoms of Mastoid involvement, for such were not present at any time during the history of the case, but on the ground that the persistent and profuse pus discharge indicated that the middle ear disease was not yielding to ordinary measures and that Mastoid and Intra-Cranial complications might possibly follow. He refused operation on the ground that he was a diabetic subject and feared the results of any operative procedure.

A few days later Dr. L. G. Visscher and Dr. Hill Hastings of this city were called in consultation. As a result of the consultation it was agreed that Mr. X. place himself under the care of Dr. Visscher for a complete study and treatment of his general condition. Dr. Visscher found a very high per cent of sugar, but reduced it to a minimum in a few weeks.

During all this time, and, in fact, up to the day before he died—with the exception of March 27th, at which time he had a slight convulsive seizure followed by stupor lasting some two or three hours—Mr. X. visited my office daily, traveled about the country, attended baseball games, etc. Aside from the

profuse discharge from the ear there were no other typical evidences of serious ear disease—no pain, tenderness, swelling or temperature.

April 25th he visited my office for the last time—that night he had a slight chill, followed by complete aphasia and partial unconsciousness—temperature 103. April 26th at about 7:30 p. m. he was taken to the operating room.

Operation revealed fluid pus in the Mastoid, a large brain abscess involving the left Temporo-sphenoidal lobe, and a collection of fluid in the Broca area, thus showing the utter hopelessness of the case. I am,

Very truly yours,

E. W. FLEMING, M. D.

This case, Dr. Fleming felt, illustrated splendidly how possible it was to have grave intra-cranial complications in these patients, without serious symptoms being evident.

\* \* \*

DR. HILL HASTINGS: Referred to several cases similar to Dr. Fleming's.

\* \* \*

DR. A. L. KELLOGG: Cited a case seen in Politzer's clinic where diagnosis had not been made.

\* \* \*

DR. H. A. KIEFER: Referred to a woman of 60 years, who upon operation was found to have an epidural abscess. Recovery was uneventful.

\* \* \*

DR. T. J. MCCOY: Spoke of "Hysterical Mastoiditis," and cited a case in which he had been thrown off the track and had operated upon a neurasthenic who had given typical symptoms.

\* \* \*

This completed the programme and upon invitation by the Chairman, Dr. Murphy, the members present gave their attention to an excellent buffet lunch provided by the members of the Eye, Ear, Nose and Throat Section of the County Association.

#### PASADENA BRANCH OF THE L. A. C. M. A.

On Tuesday evening, April 24th, Dr. W. E. Hibbard of Pasadena, entertained the members of the Pasadena branch of the Los Angeles County Medical Association at the Hotel Maryland, providing a dinner that was perfect in its appointments.

Besides the host of the evening, Dr. W. E. Hibbard, there were present the following: Doctors Geo. E. Abbott, Ralph Avery, C. A. Briggs, Solen Briggs, A. D. Condit, A. J. Crance, W.



A. Cundy, A. R. Chapin, W. V. Cook, W. D. Dilworth, H. A. Fiske, A. Fennes, Fordyce Grinnell, Wm. E. Hibbard, J. E. Janes, C. L. King, F. C. E. Mattison, S. J. Mattison, Jas. H. McBride, D. S. McCoy, A. T. Newcomb, Garrett Newkirk, A. B. Royal, W. H. Roberts, Henry Sherry, Wm. Turner, J. M. Wilson, F. A. Weir, S. Swearer, G. H. Kress, L. C. Thorpe, H. Whittemore, B. F. Church, A. I. McLeish, Hill Hastings.

After doing justice to a sumptuous menu the members listened to papers by Doctors Lewis S. Thorpe, A. I. MacLeish, Hill Hastings and B. F. Church, of Los Angeles, which papers *THE PRACTITIONER* hopes to print in some subsequent issue.

\* \* \*

Dr. MacLeish, before reading his paper, referred to Dr. George Gould's recent article in the *Journal A. M. A.*, and stated that he felt Dr. Gould had allowed himself to be carried away in his arguments in behalf of ophthalmology. He felt that Dr. Gould's article was neither wise, generous nor well-timed.

\* \* \*

Reports of cases brought forth the following:

Dr. A. B. ROYAL presented specimens of the *Screw Worm*, the larvae of a form of bottle fly, taken from the nasal sinuses of a patient who presented the following history:

Patient was a male, age 54, dairyman, who had pain in upper jaw, went to dentist, who suggested neuralgia. Patient then came to Dr. Royal. Had pain in jaw, fever to 103 degrees, chills, enlarged tonsils and inflamed soft palate. Under anodynes felt better. Next day there was a discharge of bloody pus from the left nostril. At junction of hard and soft palates a tubercle was noticed and examination revealed a screw worm, the larva worm of the bottle fly, *Comptosomya Macellaria*.

Patient was sent to hospital and the next day accessory sinuses were opened

by Dr. Hibbard and about seventy-five screw worms were cleaned out, with much foul pus.

This fly deposits its eggs in decaying matter; often depositing several thousand. The eggs hatch in one to twelve hours and attain their growth in about twelve days, when they are really rather formidable worm-like creatures. During this time worm devours both necrosed and healthy tissue. Dr. Royal saved four of the worms and hatched them in a Mason fruit jar and showed the pupa stage and these flies, mounted.

During the past year one other case had come to his knowledge in Pasadena and several in Arizona.

\* \* \*

Dr. A. J. CRANCE, referring to Dr. Royal's case of *Screw Worm*, spoke of the second case in Pasadena, which happened shortly after Dr. Royal's. This man had an atrophic catarrh, and at hospital while anaesthetic was being given, almost two ounces of the screw worms were expelled. The screw worms were very resistant in their vitality.

\* \* \*

Dr. B. F. CHURCH spoke of these worms attacking cattle in the South. A pig would wallow in the mud and the lack of air usually killed the worms, but cows not infrequently died from the suppurative and necrotic processes set up by these creatures.

Dr. Church further expressed his pleasure at being present at the meeting and his surprise at the excellent turnout and fellowship existent in the Pasadena Branch of the County Medical Association. He felt that good fellowship, no less than scientific interests should draw the members of the medical profession together and was glad to see the fraternal feeling so well exemplified in Pasadena.

\* \* \*

In the after-dinner talks that followed Dr. HENRY SHERRY spoke along the line of *Medical Fellowship*, as follows:

"We have eaten and drunken,  
Are full and not shrunk,  
Are big in the paunch and the head,  
Some are feeling quite creepy,  
And others are sleepy,  
So we ought to be home in our bed."

Before we go, however, permit me to repeat to you, as Doctors, the tribute which others have expressed in words of eloquence and touching tenderness.

In Charles Dickens' beautiful *Bleak House Tale*, the heroine, having become the wife of a Physician, renders to him this tribute, not as a man, not as a husband, but as a Physician:

"We are not rich in the bank, but we had always prospered and we have quite enough. I never walk with my husband but I hear the people bless him. I never go into a house of any degree but I hear his praises or see them in grateful eyes. I never lie down at night but I know that in the course of that day he has alleviated pain and soothed some fellow-creature in the time of need. I know that from the beds of those who are past recovery thanks have often gone up in the last hour for his patient ministration. Is not this to be rich?"

And again a layman, Will E. Dew, in the *San Francisco Argonaut*, lays at your feet this exquisite memorial:

"When in the cottage blessed with  
Love's sweet store  
A babe is born, and o'er the rustic door  
Is hung the crown of motherhood, and  
fair  
Is all within—the Doctor's there.

"When neath the pall of mystic Death's  
wield spell  
A mother's heart is broken by the knell  
Of all that's dear, and on the stair  
No baby feet—the Doctor's there.

"When Virtue flees and breath of ruth-  
less lust  
Eats into souls as does the gnawing  
rust,  
When no one else with Her the shame  
can share,  
With father's touch—the Doctor's  
there.

"Where blossoms Life's sweet Bud at  
blush of day  
Where withered Rose at eve-tide steals  
away  
On the South wind—in joy and care  
An uncrowned king—the Doctor's  
there."

## BOOK REVIEWS.

**NURSING ETHICS:** For Hospital and private use. By Isabel Hampton Robb, graduate of the New York Training School for Nurses attached to Bellevue Hospital; late Superintendent of Nurses and Principal of the Training School for Nurses, Johns Hopkins Hospital Baltimore, Md.; late Superintendent of Nurses, Illinois Training School for Nurses, Chicago, Illinois; member of the Board of Lady Managers, Lakeside Hospital, Cleveland, Ohio; Honorary Member of the Matron's Council, London, England. J. B. Savage, 90-92 Wood St., Cleveland, 1903. Price \$1.50.

This work by Mrs. Robb is a fitting companion of her excellent text book on nursing. Up to date there is no other work that covers this field. Every superintendent of nurses should put

this in her curriculum. Mrs. Robb has high ideals but they are practical and not mere theories.

A Manual of Physiology with practical Exercises, by G. N. Stewart, M. A., D. S., M. D., Edin., D. P. H. Comb, Professor of Physiology in the University of Chicago, formerly Professor of Physiology in the Western Reserve University, Cleveland; George Henry Lewes, Student, Examiner in Physiology in the University of Aberdeen, Senior Demonstrator of Physiology in the Owens College, Victoria University, etc. With colored plates and nearly 400 illustrations, fifth edition, Philadelphia. W. B. Saunders and Company, 925 Walnut street. 911 pages. Cloth, \$4.00 net, sheep or half Morocco, \$5.00 net. 1906.

One of the reasons Stewart's Physiology is so popular has been that his attempt "to interweave formal exposition with practical work," has been so successfully performed. In this last edition, which is recently off the press, the text has been completely revised and in many parts re-written and while here and there one would wish greater fullness and perhaps more extended reference to some of the newer researches and theories, the book on the whole is very ably arranged and admirably adapted to the needs of the average medical student. Physiology is one of the subjects of the medical curriculum, practitioners are only too prone to forget, once they plunge in to the responsibilities of private practice.

This should not be. We commend to those who have a desire to review some of the more recent work on the functions of the various organs of the human body, this new edition of Stewart, which is, as we stated on the whole most admirably arranged and printed.

**INTERNATIONAL CLINICS:** A quarterly of illustrated clinical lectures, and especially prepared original articles on, Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otolaryngology, Rhinology, Laryngology, Hygiene and other topics of interest to Students and Practitioners by leading members of the Medical Profession throughout the world. Edited by A. O. J. Kelly, A. M., M. D., Philadelphia, U. S. A., with the collaboration of Wm. Osler, M. D., Oxford; John H. Musser, M. D., Philadelphia; Jas. Stewart, M. D., Montreal; J. B. Murphy, M. D., Chicago; A. McPherson, M. D., Toronto; Thos. P. Rotch, M. D., Boston; John D. Clark, M. D., Philadelphia; James J. Walsh, M. D., New York; J. W. Ballantyne, M. D., Edinburgh; John Harold, M. D., London; Edmund Landolt, M. D., Paris; Richard Kretz, M. D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipzig, Brussels and Carlsbad. Volume IV., Fifteenth Series. Volume I., Sixteenth Series.

Among the contributors to the last volume of 1905, are such men as John B. Deaver, Alfred B. Thayer, Norman B. Gwynn, of the University of Penn-

sylvania and D. Barty King, of Edinburgh.

There is also a most excellent article on Phlebitis, Thrombosis and Embolism following Abdominal and Pelvic Operations, by Dr. William A. Edwards, of Los Angeles. Edwards has written in his own inimitable style on this most interesting subject, and has quoted the opinions, and reported some cases by such men as Baldy, and Maurice Richardson, in addition to some interesting cases of his own.

On the subject of Phlebitis, on page 130, he makes this statement, which will always be a comfort to those who can accept it: "Phlebitis arising under the conditions I am considering is not a septic disease; upon this most writers agree, probably I among the number, with, however, a mental reservation that will be referred to later."

On the following page, there is this statement by Richardson, of Boston: "Venous thrombosis may result from the quiet enjoined upon the patient following the operation and to prevent it he requires his patients to move their legs freely."

On the whole this article by Edwards is a very comforting one to the practitioner who has had unfortunate experiences along this line, especially if he has just previously been reading the article in Park's System of Surgery, under the heading: Phlebitis.

This same volume has an interesting and instructing chapter by Hall, of Denver, on Empyema, with a report of 30 cases.

Volume I of Series 16 contains articles by Battle, of London, Faure, of Paris, Klemperer, Nicholas Senn, Wainwright and Jas. Tyson. Among other interesting subjects, other than by those above mentioned, is an article on the Diagnosis and Treatment of Membranous Tonsillitis, by Lewis S. Somers, M. D., of Philadelphia. It is an article which every general practi-



# A Foolish Prejudice



causes many physicians to discontinue cod-liver oil during hot weather. Dr. Austin Flint says: "The weather should have no influence on its continuance provided it be well tolerated and digested" (*Pepper's System*, Vol. III, p. 434).

Hydroleine, by reason of the absolute purity of its cod-liver oil and its perfect pancreatization, is always well tolerated and digested.

Hydroleine can be given in all climes all the year around. Patients should be cautioned, however, to keep Hydroleine in the ice-box during hot weather, just as they do their butter and other perishable food. Write for sample and literature. Sold by all druggists.

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tioner could well spend the time to read, an article which throws an interesting light upon a subject which often puzzles all of us.

He places under this head Vincent's Angina, Streptococcic Tonsillitis, Pneumococcic Tonsillitis, Bacillus Coli Tonsillitis, Membranes due to the Thrush organism, Micrococcus Tetragenus Tonsillitis, and Syphilis with a membrane of the tonsils, all of which may be confounded with the membrane of Diphtheria.

In this same volume, there is also an article on the Treatment of Gastroptosis, by Albert Philip Francine, of Philadelphia. This is an article also that will bring some comfort to the Physician.

Physician and Adjunct Radiographer to the Samaritan Hospital at Troy, New York. Illustrated. W. B. Saunders Company, Philadelphia and London. 1906. Price \$1.00 net.

This book is divided into three parts. The first part treats of fever in its general aspects, which is necessary as a base to the study of each individual fever; the second part discusses each of the acute infectious fevers as to their cause, signs and symptoms, course, prognosis, care and management; the third part deals with practical procedures and information necessary in the management of the foregoing diseases, or of value in understanding the nature and course of such diseases. While this is very valuable literature for nurses, it is just the kind of a book that should be in every household.

Nursing in the Acute Infectious Fevers.  
By George P. Paul, M. D., Assistant Visiting

NURSING: Its Principles and Practice for  
Hospital Use. By Isabel Hampton Robb,

graduate of the New York Training School for Nurses attached to the Bellevue Hospital; late Superintendent of Nurses and Principal of the Training School for Nurses, Johns Hopkins Hospital, Baltimore, Md.; late Superintendent of Nurses, Illinois Training School for Nurses Chicago, Illinois; Member of the Board of Lady Managers, Lakeside Hospital, Cleveland, Ohio; Honorary Member of the Matrons' Council, London, England. Third edition revised and enlarged. Illustrated, E. C. Koskett, publisher, 115 Rose Bldg., 1906.

This standard work comes to us in its third edition, with nearly 600 pages. While it is one of the pioneer publications in the literature for nurses, yet it has kept well up with the development of that branch of professional work. It contains an outline for the division of work over the three years of instruction, which is made to include a six months' preliminary course. We believe that this work is indispensable to every teacher of nurses, and that it should be in the hands of every nurse. It, like several other works written for nurses, is peculiarly fitted for reading and reference for mothers.

THE EXAMINATION OF THE FUNCTION OF THE INTESTINES BY MEANS OF THE TEST DIET. Its Application in Medical Practice and its Diagnostic and Therapeutic Value. By Prof. Dr. Adolf Schmidt, Physician-in-Chief of the City Hospital Friedrichstadt in Dresden. Authorized Translation from the latest German Edition, by Charles D. Aaron, M.D., Professor of Diseases of the Stomach and Intestines in the Detroit Post-Graduate School of Medicine, Clinical Professor of Gastro-enterology in the Detroit College of Medicine; Consulting Gastro-enterologist to Harper Hospital, etc. With a frontispiece. Plate in Colors. Crown Octavo, 91 Pages. Extra Cloth. Price \$1. net. F. A. Davis Company, Publishers, 1914-16 Cherry street, Philadelphia.

As Schmidt well states, "our methods for examining the function of the intestine have not yet been able to secure a firm footing in practice." His purpose in writing this little book was the "desire to obtain an examination for the function of the intestines, *that could be carried out in practice*, analogous to the usual examinations for the stomach contents, and to advance by means of it the diagnosis and thera-

peutics of the diffuse intestinal diseases."

The test diet, the examination of the feces (macroscopic, microscopic, chemic and bacteriologic) and the significance of the pathologic findings in the feces are considered in the first part of the book, and the second part is given over to the consideration of Intestinal Disturbances due to the stomach, liver and pancreas, to independent disturbances of digestion and to functional disorders, therapy being here considered as well as diagnosis.

This book is by no means perfect (the author frankly points out its limitations,) but it is better and more practical than much of what we have and is on that account worthy of a place on our book shelves.

Frank M. Johnson advocates ureteral lavage of the kidneys in lithemia, pyelitis, pyelonephritis, pyonephrosia, ureteritis and chronic parenchymatous nephritis. He employs usually a solution of silver nitrate (1:12,000 to 1:2000), but when the irritation of the pelvis and ureters is particularly severe he prefers warm, soothing injections, as of boric acid. For the tenderness deep in the urethra and about the neck of bladder, which often acts as a bar to cystoscopy, the free injection of warm, soothing oils is of service.

The location of the heart beat had best be determined by its distance from the medium line, and not from the nipple line, as the location of the latter varies in different persons. If the apex beat is not perceptible, it can be located by slight percussion.

The temptation must not be yielded to to incise a psoas, hip or other "cold" abscess, except in isolated instances and then only under the most rigid asepsis. The production of a mixed infection means chronic sinus, chronic invalidism and, often, amyloid disease.

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DR. WALTER LINDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## "THE PHYSICIAN'S DUTY TO HIS PATIENT," AN ADDRESS ON ETHICS.\*

BY WALTER LINDLEY, M. D., LL.D., LOS ANGELES, DEAN OF THE COLLEGE OF MEDICINE,  
OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

Ethics means the science of doing right, the science of human duty. It is living day by day the Golden Rule in outward actions and inward spirit. Ethics is the ripe fruit of a noble soul.

There is in life today so much that is material, so much that points toward money making, so much teaching of the things that are supposed to help you win the race from your fellow man, that it is well for us to pause a moment and ask ourselves: What is our duty to our fellow man?

As physicians we will consider the subject under three subdivisions: One, Our Duty to Our Patients; Two, Our Duty to Our Fellow Practitioners; Three, Our Duty to the Public. Today we shall consider the first of these subdivisions: Our Duty to Our Patients.

The physician is admitted into the most sacred chambers of human life. The sick room is the house of God. The patient places his life in his doctor's hands. More than that, the patient frequently confides in his physician in re-

gard to his business and family. He trusts the man he has chosen for his medical attendant. Be worthy of that trust. Teach your patients that they may have absolute faith in you.

Your patients must provide you a living, but get that living honorably, get it without being hard on any poor person, get it without grinding. The question is asked: "Shall a physician dispense his medicines or write prescriptions?" My answer is, do both. If your patient is well to do, you can prescribe for him, and he can thus have his medicines put up in a more elegant manner than if you dispense them. If your patient is poor and needs a laxative, give him a few aloin, belladonna and cascara tablets, that cost you but a few cents per thousand. If a little strychnia is needed, you can save your poor patients much money by using tablets. For your principal remedies you will probably find it best to write prescriptions. In that event try to write as inexpensive prescriptions as possible.

\*Lecture delivered to the Seniors of the College of Medicine of the University of Southern California, March 8, 1906.



When I was a boy I read a story by Charles Reade, the title of which is "Put Yourself in His Place." Put yourself in your poor patient's place. Remember, poverty is terrible; add sickness to poverty and hope vanishes. Have an understanding with your druggist that when there is a certain hieroglyphic on a prescription, he is to know the recipient is a poor patient, and that the medicine is to be furnished at as near cost as possible.

Do not make for yourself any rule that you will always dispense, or that you will always prescribe, but simply do what is best for the case in hand. Teach your druggist that he must charge poor people the least possible amount.

Just a word more along this line. That "honesty is the best policy," is an axiomatic saying. But that is a poor reason for being honest. Still, it is better to be honest through mere policy than not to be honest at all. Consideration for the poor is the best policy. The poor patient this year often becomes the rich patient next year. As a rule he will never forget your kindness. Be charitable, then, through policy, if for no other reason.

Often you will be appealed to by a wife, or by the father or mother of some troubled wife, to advise in regard to securing a divorcee from a more or less dissolute husband. Do what you can to preserve intact the family. Many men go wrong, and then come around all right. Let your arguments, your conversation, your influence, all be in favor of the perpetuity of the home.

As a rule the physician should be frank and open with his patients. If a patient has tuberculosis, such a patient should, for the protection of those about him, and for his self-protection, be told that he has tuberculosis. After once telling him his real condition hold out all of the hope possible. Present the optimistic view of every condition.

Try to imbue every patient with hope. There is a hopeful side of almost every case. In my early practice I frequently pronounced the death warrant. Every year surprises would come. People would thoughtlessly recover who, according to all of the text-books, should have died. "While there is life there is hope." Fan into a flame every spark of hope, and thus utilize to its utmost, Nature's most potent remedy. Sometimes it is best to not tell a patient his real condition. Such occasions are rare. Then if asked the disease you may give a technical reply. This is getting to be an intelligent world. It is demanded that the practitioner talk in good, plain, understandable language.

Do not talk Latin to your patients. Endeavor never to mystify them. Encourage every intelligent family that you attend to purchase a few good books that will teach the care of the sick in plain language. The best books for patients are those written for nurses. General text-books on nursing, books on food and diet in health and disease, and especially books on obstetric nursing are excellent for family reading. A few years ago there was not a book written especially for nurses, now there is a library of them. About three or four of these, well selected, will be of great aid to a mother in caring for her family.

Do what you can to eradicate superstition wherever you may go. As the sparks fly upward, so is man drawn to the superstitious and the occult. It was not so very long ago that it was popular to scrape thoroughly the tombstones of the graves of the saints. The powder thus obtained was then put into water or wine, and thus a medicine was acquired which was supposed to possess an astonishing curative power. An historical character of that day said of it: "Oh, indescribable mixture, incomparable elixir, antidote beyond all praise! Celestial purgative, which throws into

the shade every medical prescription, which surpasses in fragrance every earthly aroma, and is more powerful than all essences; which purges the body like the juice of scammony, clears the lungs like hyssop, and the head like sneezewort; which not only cures the ailing limbs, but also, and this is much more valuable, washes off the stains from the conscience." Just as wild claims are made today for most unreasonable things. In trying to educate your patient away from superstition be careful that you do not prejudice him against religion. Superstition is to religion as a wart is to a nose. Remove the wart but leave the nose.

The vagaries of the human mind are wonderful to contemplate. Take Christian Science, whose believers claim there is no such thing as pain, disease or death. That cult has hundreds of thousands of followers. Do not abuse or villify, or when a Christian Scientist gets sick and sends for you do not say "I told you so." Go along quietly, usefully, consistently, and let your daily walk in life be the strongest argument for rational belief and rational systems.

How shall you collect your bills? In a fair and systematic manner. In a business-like way. Try to get business habits. It is an awful task when your heart is full of interest and enthusiasm in a case, when you are deep in scientific study, to have to stop and enter sordid dollars and cents in your books. It records such an intellectual fall. It is terrible. I sympathize with the physician who chafes and rebels at the mercenary side of the practice of medicine. It is detestable. Still it is necessary. You should be accurate and send out your bills, as a rule, at the first of each month. Do not harass or bring suit in order to collect. Such insistence might be intrinsically right, but practically wrong.

Know the financial condition of a patient before you press a claim. There

are 13,000,000 families in the United States, and of these only 5 per cent. have incomes exceeding \$3,000.00 per annum, counting both the proceeds of invested capital and the earnings of the entire family. One-third of all the American families live on less than \$400.00 per year, and over one-half live on less than \$600.00 per annum. Remember these are families, not individuals.

How are these people with very small incomes to receive skilled medical attendance without losing their self-respect and independence through becoming recipients of charity? Railroad employees are banded in what might well be called companies insuring against sickness. By paying fifty cents or one dollar per month each they receive as their right medical treatment and hospital care whenever they are sick or injured.

To accomplish the same purpose many who are not railroad employees have organized themselves into fraternal societies where they pay systematically a fixed monthly sum, and receive medical treatment and hospital care when they are ill, and decent burial when they die.

I can readily understand the comfort a man of family, who earns only \$2.00 per day, might derive from knowing that the medical care of himself and his family was paid for in advance. There has been a great deal said against the railroad contract physician, and the lodge contract physician, but I am not going to lay down any rules for you in these matters.

Be as independent of all masters—excepting and alone the master spirit of serving your patients—as you possibly can. There is nothing dishonorable in being a railroad physician, a lodge physician, a physician for a mining company, or a physician for any other corporation. As to the advisability of it, you must each one of you settle that for yourself. Whether you work

for a lodge or a railroad, see to it that the poorest member or employee receives just as thoughtful and assiduous care as your wealthiest patient. When you once assume the charge of a patient do your utmost to cure him. You must treat individuals, not diseases. First, make the diagnosis. To do this the laboratory, the library and your experience must be drawn on. Neglect nothing that will aid you in securing a clear idea of the condition. Take abundance of time in making an examination. By being thorough in your methods of making a diagnosis you will have a clear conscience and your patients will respect you.

When it comes to treatment you must be ready to make any sacrifice. You have assumed the responsibility of a life. Let there be no limit to your exertion, to your self-sacrifice to save that life.

A few years ago when the radical operation for hypertrophy of the prostate gland had only been performed two or three times on the Pacific Coast, I passed through a Los Angeles hospital at 1 o'clock in the morning, and there pacing up and down the corridors, stopping now and then to look at his patient, was a well-known Southern California surgeon. He had done a prostatectomy the previous day, and his patient was not doing well. He had taken him back to the operating room, and was now doing everything possible to maintain his vitality. For three days and nights this surgeon, whom you all know, watched that patient. Today the patient, whose life that night hung by a thread, is at the head of a great educational institution, while the surgeon has since successfully performed that operation scores of times. I have known men who would neglect a patient rather than miss a good dinner, a social function or a play. Such men should never practice medicine. The true physician in testing his balances will find that the

claims of his patient outweigh all others.

Do not preach to your patient. Yet you can frequently, in a quiet way, say a word that will steer this frail bark, known as man, away from dangerous shoals.

There is abroad a most fallacious theory that the young man must go through a certain amount of dissipation. Some fathers, filled with this idea, deliberately send their sons to houses of ill-fame. This is certainly a bizarre doctrine, but it is a cruel and disastrous one. Many physicians most inately joke with the young man in regard to his excesses. It may not be the physician's duty to talk much about the right and wrong of things, but it is emphatically his duty to point out to the young man the road that leads to mental and physical health, and warn him most earnestly of the disaster that follows intemperance, incontinence and their accompanying diseases.

Intelligence, education, industry, economy, a spirit of good fellowship, sobriety, persistency of purpose and health mean success. The corner-stone is health. Do all you can to impress the young man to guard his health as his most precious heritage. Never talk of your patients. Avoid that habit. Some physicians have it bad. Especially remember that you are the people's confessor on all physical delinquencies, and that all revelations must be sacred. Do not tell your wife about your cases. Talk on other subjects in your family circle. Get away from shop at home. It was only a few years ago that the most prominent physician in London cured a lady of high position. He had his suspicions, and told his wife, who, in confidence, told her best friend. The result was the doctor lost his practice, had to pay heavy damages, and he who had basked in the illuminating favor of royalty was socially ostracized and ruined. Don't do



it. If you are not sure that you can keep these vital confidences inviolate, either do not practice medicine, or do not marry.

Theologically, the confessional is a failure except where the clergy are celibates. Medically I do not believe that celibacy is generally necessary in order to be absolutely true to your patient. Commune only with your own soul about the moral and physical delinquencies that are revealed to you professionally. You will remember that Tennyson says:

"And yonder a vile physician, blabbing  
The case of his patient, . . . .  
For I never whisper'd a private affair  
Within the hearing of a cat or mouse,  
No, not to myself in the closet alone,  
But I heard it shouted at once from  
the top of the house;  
Everything came to be known."

Be patient and tender. Medicines, surgery, massage, hydro-therapy and electro-therapy all have their places, but a patient, optimistic tenderness is a great curative factor.

In conclusion: "What is your duty to your patient?" An educated conscience can tell you better than any lecturer.

Within the last few years a book carrying a most pernicious doctrine

gained a marvelous circulation. This book is a fascinating mixture of crude English, slang, cunning and human nature. Its aim is to supplant the beneficent teachings of Jesus Christ with a new Golden Rule, which is "Do unto the other fellow as he would do unto you, but do it first." This may be good doctrine for a horse trader, but it takes out of man the most important element of a gentleman. To do his duty to his patient, and at the same time give due consideration to his own family, the physician must have an altruistic spirit combined with the highest type of business methods.

The life of the true physician is full of opportunities of being useful to his fellow man. Make the most of these opportunities, and by so doing you will doubtless be reasonably successful in a material sense, and will also achieve a success in life that will give you a happiness that will make it possible for you in your daily life to sing with the poet:

"O what a glory does this world put on  
For him who with a fervent heart goes  
forth  
Under the high and glorious sky and  
looks  
On duties well performed and days well  
spent."

## THE ROLE OF THE PERITONEUM AND OF THE LYMPHATIC SYSTEM IN ABDOMINAL SURGERY.

BY ALBERT J. BOUFFLEUR OF CHICAGO, ILL., ASSISTANT PROFESSOR OF SURGERY, RUSH MEDICAL COLLEGE, CHICAGO, ILL.

While the various organs and regions of the body have been the objects and scenes of surgical activity, no region has contributed more to the evolution and progress of Surgery than the abdomen. The surprising successes of pelvic work in the female, even in the hands of tyro operators, revealed long

ago a remarkable degree of tolerance and recuperative power on the part of the peritoneum and with that revelation a spirit of boldness has developed which at times seems to border unto rashness.

These phenomenal successes must be dependent upon anatomic and physiologic reasons as well as upon the pathologic

\*Abstract of remarks delivered by request before Los Angeles County Medical Association, March 30, 1906.

gical fact that most of the infections in this region in women are caused by a peculiar self-limiting micro-organism. This tolerance was for a long time explained on the basis that through the continuity of the endometrium and the peritoneum via the Fallopian tubes, a condition of more or less constant inoculation of the peritoneum of woman occurred which rendered it less vulnerable to the effects of trauma and pyogenic infections. While the claim of a condition of relative immunity is justifiable, this anatomic fact cannot be wholly responsible for the successes of pelvic work since infections in the lower abdomen in male patients are less serious than the same character of infections is in the upper zone. The arrangement and function of the lymphatics constitute one of the most important factors in determining the behavior of inflammatory processes in the various regions of the abdomen.

It is pertinent to recall the relations of the peritoneum. Its relations to the abdominal wall in the upper zone, including the diaphragm are most intimate, while in the lower part it is loosely attached and behind simply overlies the organs and structures. Its relation to the viscera also varies. It forms the capsule of the liver and spleen, furnishes the accommodating envelope of the stomach and intestines, and a partial covering of the duodenum, colon, rectum and uterus, while it has no direct relationship to the kidney, ureter, etc. The great omentum is comparatively free, and is usually found where most needed, thus acting as does a veritable Flying Squadron in navy warfare.

The peritoneum can be considered as a part of the general lymphatic system possessing three functions of surgical interest:

1. The power of destroying bacteria and toxins.
2. The power of absorption.
3. The power of exudation or protection.

The normal peritoneum of a patient with good body resistance has marked germicidal power. A moderate amount of pus cultures are readily disposed of by a normal peritoneum while sterile foreign bodies like gauze and even feces are harmless as long as they remain sterile. But if the pus is in a mass of feces, lymph or other material where it is protected and the bacteria multiply therein, it will soon cause peritonitis—local or general according to the amount, character, virulence and location of the infecting micro-organism. A peritoneum damaged by trauma or infection has a relatively small destructive power. It is always on the defensive.

The vigor and resisting power of the patient is a strong factor in disposing of infection and if to this we add the local and general immunity of repeated infections we can understand the relatively different behavior of tissues and individuals after primary and secondary infections and also in the healthy patient with good hemoglobin from those reduced by pneumonia, typhoid, etc. While this destruction or detoxination may be largely a systemic process the peritoneum seems to have exceptional power in this respect. As this power depends upon the normality of the peritoneum and the resistance of the patient we

- (a) Should not traumatize the peritoneum by rough or unnecessary manipulation nor by allowing it to dry—and
- (b) Should consider the patient's resistance; weak, starved, anaemic, exhausted patients demand rapid and clean work with least possible manipulation.

The lymphatic system aims to destroy as much as it can locally, to attenuate by dilution and thus to render less virulent that which it cannot destroy and in this liquid form to carry it away, and allow the lymph and other glandular organs to chemically transform the exudate, bacteria and toxins into innocuous, or at least less toxic substances which will finally be cast out by the excretory organs.

As the absorptive power belongs to the lymphatics of which the peritoneum is simply an expansive part, let us consider briefly the lymphatic supply of the various organs and see if therein we cannot find an explanation for some of the variations in the behavior and expressions of infections in the different organs and regions. The *liver* is deficient in lymphatics and hence abscess produces few or no symptoms unless it empties into a vein or involves the peritoneal capsule. As soon as it does either septic symptoms are markedly manifested. The *gall bladder* has a small lymphatic supply and hence septic symptoms from infections therein are usually not marked—the temperature usually ranging from 100 to 101 degrees. The cystic duct is more freely supplied with lymphatics and therefore infections thereof are accompanied by more symptoms of absorption and the temperature may vary from 100 to 104 degrees. The lymphatic supply of the common duct is very rich and therefore symptoms of absorption are most marked and the temperature is usually of the pyaemic type. The suddenness and intermission of the temperature is characteristic of what Dr. Murphy calls the “temperature angle of cholangic inflammation.

The *kidney* is poorly supplied with lymphatics and therefore infection within its substance produces septic symptoms only when it reaches the pelvis or perforates the capsule, when areas rich in lymphatics are reached. Incidentally it might be noted that as exudation is by the blood vessels and absorption by the lymphatics these organs with poor lymphatic supply—the liver and kidneys—are subject to sclerosing processes.

The *stomach* has a rich lymphatic supply about the lesser curvature and pylorus but very little about the fundus. The definite lymphatic circulation of the right half of the stomach explains the practicability of gastric resection. Infection of the gastric wall

does not produce symptoms of sepsis until the proximal lymph gland is passed or the peritoneum is involved, when, being in the upper abdomen, the symptoms are very marked.

The *small intestines* are richly supplied with lymphatics, hence septic symptoms of infection and particularly obstruction appear early and are marked.

*Appendix vermiformis* has a variable lymphatic supply and hence the variation in symptoms from infection. Usually its lymphatics are very moderate and very small, and therefore easily obstructed. Dr. Murphy claims there is always some temperature within the first thirty-six hours in appendicitis—the earlier it appears the more acute. The lymphatic supply and action of different bacteria explains varied temperature in appendicitis. When we have a primary infection with the colon bacillus, etc., with gradually increasing temperature, terminating in gangrene and peritonitis with high temperature, we have a picture of sequence which is easily understood—but when a patient apparently well, is suddenly taken sick—without temperature at the time but one rapidly develops, is operated within a few hours and gangrenous perforation found, the conditions and absence of general septic symptoms at beginning of attack are not easily understood. It must be conceded that the colon bacillus has been working for several hours, as gangrenous sloughing cannot occur instantaneously. How then can we explain the absence of septic symptoms before the peritoneum was involved? It can easily be conceived how a slight pus infection may have existed for a week or two, and have produced sufficient exudate to block the few small lymph channels, and at the same time have weakened the appendiceal wall. A weakened or traumatized wall allows the colon bacilli to pass through readily and the blockage of the lymph channels might allow the



bacilli to produce extensive destruction of the mucous and muscular coats without any toxins entering the general system to produce temperature until the peritoneum was involved when sudden high temperature would result.

This also explains that a secondary temperature is caused by peritonitis, and why it is always a serious matter in appendicial inflammation.

The *large intestine* is richly supplied with lymphatics but they are largely exudative and not absorptive in function which explains the lateness and slightness of septic symptoms in infection or obstruction of this part of the alimentary canal.

The *uterus* is very rich in lymphatics and they are peculiar in that many pass directly through the organ connecting the endometrium with the peritoneum without the intervention of any glands, which explains the frequency of pelvic peritonitis in intra-uterine infection and the futility of ordinary local intra-uterine applications and frequent curettage in the treatment of active inflammations in this organ.

The *prostate* is itself poorly supplied with lymphatics, but as both the urethra and the prostatic capsule are rich in lymphatics, the symptoms of sepsis are usually quite early and were formerly, before early drainage, frequently fatal.

The absorptive power of the whole peritoneum is estimated to be 3 to 8 per cent. of the body weight in one hour, which explains the great dangers of acute septic peritonitis and the quickness by which the normal resistance of the organism may be overwhelmed, and it also indicates the great value of the peritoneum as an avenue for the restoration of the circulatory equilibrium by the use of normal salt solution in aseptic cases, especially when caused by marked loss of blood.

This absorption takes place largely through the peritoneum of the diaphragm and upper abdominal zone

which explains the relative seriousness of infection of the upper abdomen over those of the lower zone. The current of lymphatic circulation in a closed abdominal cavity is upwards, which also explains the location near the diaphragm of secondary abscesses following appendicitis, and also the occasional occurrence of death from fatal sepsis after removal of an appendix even though the lower abdomen may have been rendered thoroughly clean at time of operation and have remained so afterward.

The fact that absorption occurs largely through the upper zone is one of the factors in the successful treatment of septic peritonitis of today.

The third function of the peritoneum is exudation or protection. Exudation upon the slightest irritation is characteristic of all serous membranes. It is nature's method of covering abrasions, closing wounds and of limiting inflammation. The character of the exudate varies with the degree and character of the irritation. The slightest irritation produces a serous exudate; more severe, a fibrinous exudate, while pyogenic infection produces a purulent exudate, which varies in color, consistency, odor, etc., with the variety of micro-organism concerned. In some cases the irritation is so great that there seems to be no time for exudation—the endothelium being quickly destroyed and a dry peritonitis resulting. These cases are naturally of the fatal type.

Only fluid exudates can be absorbed by even a normal peritoneum and if the lymphatics are damaged, or are obstructed by a thick exudate or by pressure even serous exudates are not absorbed.

Plastic exudation is the source of all salvation in abdominal injuries, inflammation and surgery. It covers abrasions and defects, and admits of normal repair beneath. The primary closure of all wounds is by agglutination of the peritoneum to peritoneum or

a raw surface which is followed by plastic exudation and ultimate organic union. This ability of the peritoneum to quickly unite with peritoneum or raw surfaces is the basis of all successful abdominal surgical technic.

While this plastic exudate is the object of our desires and aims it becomes the source of our anxiety and only too frequently of our grief when pyogenic organisms are present. Being coagulable, it is non-absorbable and therefore remains as the harbinger and incubator and food of its contained bacteria. The more plastic an infected exudate the more prolonged will be the dangers of the inflammatory process.

The character of the infection and its resultant exudate determines the method of operating and the question of and character of drainage. The more active the infection the greater necessity for little and clean operative work, and conversely, the milder and more chronic the process the greater freedom for complete operative technic.

The determination of the question of drainage depends upon: 1. Asepticity. 2. Trauma. 3. Oozing.

An aseptic cavity with normal peritoneum naturally does not require any drainage if hemostasis is good. If considerable oozing persists it is desirable to use a gauze pack to control the bleeding and as a capsillary drain it will deliver the blood to the surface. Blood in itself is not particularly objectionable but in the presence of even a slight infection it may act as the harbinger and food for the formation of a dangerous and destructive army of microbes. The indications in aseptic cases are to remove the blood clots and to restore the vascular equilibrium by 1st, the introduction of normal salt solution into the abdomen and 2nd, placing the patient in Clark's inverted position to favor absorption. If blood pressure is low adrenalin should be

added to the solution. If a pack must be left, establish a practically intact peritoneal cavity so as to restore intra-perilymph current in the cavity. Tubes will not permit of this and they have no place in aseptic laparotomies. There is a large class of operations in which only comparative asepsis is attainable as in removing a chronic pyosalpinx or chronic appendicitis. If the peritoneum is normal and has not been much traumatized and there are no masses of lymph or feces containing bacteria left and hemostasis is good and if patient's resistance is good there is no need for drainage even temporarily. On the other hand, prolonged operations with much manipulation inhibits the destructive and protective power of the peritoneum, at least temporarily, and thereby prevents the destruction of any remaining infective material and allows the serous exudate to accumulate, which may distribute the local infection throughout the abdomen or mechanically interfere with absorption by compression of the lymphatics. Temporary drainage is of great service in such cases and the exudate being serous, gauze is usually efficient.

In all active infections of the peritoneum the indications are plainly, 1, to localize the infection; 2 to lessen lymphatic absorption and 3, to provide for free external drainage.

We can localize the infection by gauze packing; the gauze irritates the peritoneum and favors plastic exudation which is followed by granulation tissue, which having so many leucocytes to feed upon, grows rapidly. As it will require five days for formation of a good protecting layer of granulation tissue the gauze should be left that long before removal. Iodoform increases the irritation and the plasticity of the exudate and acts as a disinfectant which makes its use commendable.

We can further favor localization by intestinal quietude which lessens dis-

tribution and absorption and favors formation of adhesive walls.

We can lessen the absorption by irrigation with hot salt or other solutions. It mechanically dilutes and removes the infection and the exudate. Very hot solutions greatly lessen the absorptive power of the peritoneum. It is claimed by some that very weak formalin solutions are even more effective and we are experimenting with still other substances which not only inhibit absorption but favor serous exudation into the peritoneal cavity.

We can establish free external drainage by placing the patient in the sitting or Fowler position with large tubular drainage which is essential for free drainage and for the destruction of the lymphatic current present in the closed peritoneal cavity.

Large tubular drainage means free drainage while gauze drains mean at best slight drainage for only a few hours after which it acts as a plug which not only prevents external drainage but closes the peritoneal cavity and favors absorption. External drainage is encouraged by some operators by repeated flushings of the cavity—but Murphy's plan of overloading the general circulation by a continuous enema of weak salt solution which after being absorbed is thrown off by the peritoneum seems to be the most rational, and to have given the most uniformly satisfactory results.

The large number of cases of diffuse septic peritonitis which we are now able to tabulate as having been successfully treated by the sitting position with free drainage forms one of the most gratifying steps of progress made in surgery during the past decade.

From the foregoing we feel that we are warranted in concluding: 1. That the varied lymphatic supply produces a variance in the behavior and manifestations of infections of the different abdominal viscera and may account for

the diseases most frequently manifested in some of them.

2. That the normal peritoneum possesses marked powers of exudation and absorption.

3. That both of these functions may be life saving or death producing accordingly to the asepticity of the peritoneal cavity.

4. That while all parts of the peritoneum are capable of both exudation and absorption, the lower or pelvic zone is most exudative and the upper zone most absorptive.

5. That the difference in relative powers of upper and lower zones explains satisfactorily the evident fact that infections in upper peritoneum are more acute, more serious and produce marked symptoms more promptly than in the lower and the operations in the upper zone are attended with greater risk than those in lower abdomen.

6. That in aseptic cases we can favor restoration of circulatory equilibrium by introducing fluids into the abdomen and favor its absorption by Clark's inverted position.

7. That in septic conditions we should lessen absorption, localize exudation in lower abdomen and provide for its rapid external drainage by Fowler's sitting position and the use of large tubular drains.

8. That as the condition of the peritoneum and the recuperative powers of the patient are equal factors with asepticity in attaining results, time and trauma are especially important elements in successful abdominal surgery.

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It is claimed that in some chronic cardiac diseases with very low arterial tension, no drug gives better results than digitalis in doses of five drops four times a day.

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For severe headache at any stage of pneumonia, apply the ice bag to the head as frequently as necessary.



## EMERGENCIES IN INTERNAL MEDICINE—TREATMENT.\*

BY J. H. UTLEY, M. D., PROFESSOR OF MEDICINE IN THE COLLEGE OF MEDICINE OF THE  
UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES, CAL.

If we accept as correct Gould's definition of an emergency as "A sudden, unforeseen occurrence, calling for immediate action," then it is very apparent that we have a wide field to cover in the few minutes at our disposal this evening. It would be unprofitable to attempt to enumerate even the emergencies which may be encountered by the medical practitioner, to say nothing of their treatment, but we will take up, necessarily very briefly some of the most important ones, and consider what can be done for them.

*Pain* is only a symptom of an organic or functional fault of which it is a manifestation, but it may be so severe that immediate relief is demanded. Of course an accurate diagnosis should be made if possible, but the patient is quite ready to wait for that until you make him more comfortable. The treatment of *neuralgias* of the trigeminal, cervico-occipital, brachial, intercostal and sciatic varieties may be divided into measures employed for the relief of pain and those employed for conditions which act as exciting causes.

Tonight only the first of these will be considered. Local applications of various sorts often give great relief. We may use heat, dry and moist: for example, the little Japanese stove or flannel wrung out of hot water; counter irritation in form of mustard poultice or liniment; remedies, such as menthol, in ointment, or analgesique or salicylic acid. Then we employ by hypodermic or mouth some form of opium, morphia or codeine generally. A small dose of morphia, say an eighth or tenth of a grain, is usually more of an anodyne than four times that amount of codeine.

Then the coal tar preparations may be used. The most efficient in my experience is acetanilid, probably also the most dangerous on account of its effect on the heart. In robust subjects it can be used in moderation with great relief, but it should always be safeguarded with a stimulant, such as caffeine or strychnia. Gelsemium will sometimes give good results in facial neuralgia. In my experience croton chloral does not help much.

The severe pain of a *developing alveolar abscess* may defy any form of treatment short of positive anaesthesia. Galvanism may be very successful in intercostal neuralgia and lumbago, while forcible extension of the limb may stop a sciatica, as may also deep injections into the nerve of cocaine or chloroform.

The agonizing pain of *gall stone and nephritic colic* demands large doses of morphine, or the administration of ether, while the pain of *acute appendicitis* should only be mitigated by the use of the ice bag and irrigation of the colon before seen by the consulting surgeon. The pain of *acute indigestion*, both gastric and intestinal, is generally promptly relieved by irrigation.

*Hemorrhage*, if at all severe, calls for prompt treatment. When *due to traumatism* surgical measures are generally employed, but in many mucous membrane hemorrhages the treatment is medical. Those which we have to deal with most commonly are *epistaxis*, *haemoptysis*, *haematemesis*, *haematuria*, *menorrhagia* and *melaena*. When the site of the hemorrhage is near an external opening, like the nostrils or anus, the local application of a solution of adrenalin is often highly successful. In

\*Read before the Los Angeles County Medical Association, June 1, 1906.

obstinate cases of *epistaxis* the use of a solution of cocaine to render the mucous membrane less sensitive, with the free use of the solution of adrenalin chloride and careful packing with gauze moistened in a solution of alum has given me excellent results.

In *haemoptysis*, *haematemesis* and *haematuria*, adrenalin does not act particularly well, for we cannot apply it directly to the bleeding surface without its being very much diluted in the stomach by the gastric juice, and in the bladder, if hemorrhage is from that organ, by the urine.

In *haemoptysis* (from the lungs) the local effect of adrenalin administered by the stomach or hypodermically is, to say the least, very problematical. Best results are obtainable by placing the patient in bed, enforcing absolute quiet, with ice bag to chest; morphine and atropine by hypodermic if hemorrhage is not so great as to endanger the flooding of the lungs; withholding food and drink; passing ligatures about the legs to hold out some of the blood from the general circulation, and to reduce arterial pressure; and giving calcium chloride in suitable doses. When there is much vascular excitement, aconite is indicated. Ergot and various astringents probably are harmful. It is certainly remarkable, all things considered, how few patients die of hemorrhage of the lungs. I remember to have seen but three.

*Haematemesis* with free hemorrhage is generally due to ulcer. The treatment of this emergency with drugs is very unsatisfactory, and surgical measures are much more frequently employed than formerly. Absolute quiet, withholding food and drink, the use of morphine, hypodermatically, and perhaps ergotin, with ligatures about the legs and subcutaneous injection of saline solution if necessary, are all indicated. Lavage of the stomach, followed by

astringents, such as gallic acid, is recommended, but I have found little benefit from it, and in one case absolute harm, for it was followed by severe vomiting and increased hemorrhage.

In *menorrhagia* the drug of most value is ergot, perhaps best employed hypodermatically. Other valuable remedies are stypticin, hydrastin, cannabis indica, cottonroot, etc. Tamponing the vagina and uterus may be necessary, and sometimes in the enlarged organ electricity acts well.

*Haematuria* will be considered by Dr. Newmark. *Hemorrhage* from the rectum can be treated locally by the use of adrenalin solution, and astringents, but when it comes from higher up in the intestine, and is copious enough to constitute an emergency, the case is surgical, unless we are contented to adopt an expectant plan. For *slight intestinal hemorrhage*, dilute aromatic sulphuric acid, opium and turpentine are valuable.

*Coma* is a condition of insensibility produced by so many different causes that I cannot in a few words deal with its treatment in an intelligent way, but it is certainly one of the most important emergencies which we meet in every-day practice. When it appears suddenly it may be due to *apoplexy*, *sunstroke* or *cataplexy*. It develops more slowly in *acute infectious diseases*, *narcotic poisonings*, *toxæmias of chronic diseases*, and in *brain affections*.

In combating the *coma of opium poisoning*, we should evacuate the stomach, maintaining respiration by moderate doses of atropine, faradization of chest muscles, cold and hot applications, and artificial respiration, and stimulating the circulation by strychnia, caffeine, rubbing, etc. Sometimes dilatation of the sphincter ani is of value.

*Alcoholic coma* is treated in the same way, aside from the use of atropine. If we cannot perform lavage, a hypo-

dermic of apomorphia, 1-12 to 1-8 gr. generally has a prompt effect. Inhalations of ammonia or amyl nitrite are also used.

In the *coma of apoplexy*, we have no successful drug treatment, and can practically do nothing with cerebral hemorrhage. Cushing of Baltimore has recently shown that high arterial pressure in this condition is due to an effort on the part of nature to maintain the blood supply to the vital centers at the base of the brain. And if this blood supply cannot be maintained because of lowered blood pressure, then death soon occurs. Therefore we should not perform venesection nor give vascular sedatives, but if arterial tension falls give atropine. Venesection, however, does apparently restore consciousness. If there is vomiting, turn patient on side to promote free drainage, and avoid food being drawn into larynx and lungs; draw forward the tongue if necessary, and elevate the head only slightly.

The *coma of chronic diseases* is usually a terminal event, and is principally of interest from the standpoint of prognosis.

A *convulsion* is always considered to be an emergency, and prompt action on the part of the attending physician is expected. Frequently the *convulsions of childhood* are not serious in their results, but they are always alarming to members of the family. Easily excited, so-called nervous children may have a convulsion on slight provocation, such as cutting a tooth, gastric indigestion, etc., and it can often be relieved by a warm bath, cool applications to the head, inhalation of ammonia, lancing the gums, emptying the stomach, etc. It may be necessary to use ether or chloroform with musk or belladonna, and chloral hydrate by enema is of value. An accurate diagnosis of the cause underlying the eclampsia is of greatest importance in dealing with

these cases in order to prevent future attacks.

Convulsions in adults from *epilepsy*, *uraemia*, *strychnia*, *brain tumors*, etc., I find I have not time to consider, but wish to say a few words about *hysteria* before closing.

When the patient is seen by the physician for the first time in an epileptiform convulsion, the diagnosis may be difficult. However, if the patient is a young woman, with a history of nervous irritability and lack of self-control in regard to her emotions and impulses, and if she does not hurt herself, bite her tongue, nor froth at the mouth, the case is probably one of hysteria.

The facial expression is generally characteristic, differing from the facies of an epileptic, and often it can be seen that she is conscious of what goes on around her. In the treatment of the hysterical attack we have an excellent remedy in amyl nitrite. It usually causes prompt relaxation and has a powerful mental effect as well. When amyl cannot be obtained, ether should be used in preference to chloroform, which may lead to formation of the habit. A hypodermic of apomorphia also is efficient. The use of the actual cautery to various spots along the spine often has a very salutary effect, but you may lose a patient by employing it.

In closing I wish to say that I fully appreciate your patience and courtesy in listening to such a hastily written paper; one which I know to be entirely inadequate to the subject presented. The very scope of the subject forbids anything like a complete or thorough consideration of its many phases.

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For ivy poisoning, ichthyol, used in a one to three solution, will be found to reduce the swelling, lessen the heat and itching, prevent the spread of ivy poisoning.



## EMERGENCIES IN SURGERY—TREATMENT.\*

BY JOSEPH KURTZ, M. D., LOS ANGELES, CAL., PROFESSOR OF CLINICAL SURGERY, COLLEGE OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA.

Some surgical authority made the remark (in connection with a report of gunshot injuries): "The first assistance frequently determines the result of the case." This means really the emergency treatment. The remark is applicable to a great many injuries, and I may say that often an injured person would have been better off if his first assistance had not been any more than to bring him to a place where he could have had the best treatment.

An example of this: Some years ago I was called out in the night to see a man who was cut in the abdomen. I found him in a saloon on a table, a doctor holding his hand over the wound, from which about three inches of bowel was protruding. He told me that he had tried for about half an hour to press the bowel back, but could not succeed. No antiseptic or any proper means of dressing the wound was near. I covered the wound with gauze, and had the patient immediately removed to his home, where I enlarged the wound, and after thoroughly cleaning the bowel and convincing myself that there was no wound in the bowel itself, returned this with greatest care. But the man had peritonitis and died. Was I responsible for his death, or the one who tried first assistance on him? Or was death due perhaps to an infected knife?

Emergency cases receive their first treatment by all sorts of people, the majority of them by the laity, and many of them by the ambulance men, then by the nurse, and after that by the surgeon. It seems to me, therefore, that it would be wise that everybody be taught a little of what to do in case of an accident.

In Germany every soldier is taught what to do with himself or with his comrade, if shot or injured on the bat-

tlefield, before the organized ambulance assistance arrives. He carries in his knapsack some antiseptic material with which to make a dressing which will protect him against infection at least. I understand that the ambulance men of our city are similarly equipped. But so much cannot be expected of everybody, and yet injured people are frequently assisted by those who know nothing at all about how to handle a patient.

I would therefore suggest that our teachers should to some extent instruct their advanced pupils either how to render some assistance or else how to see to it that nothing is done to the injured person before proper assistance arrives.

Trained nurses receive such an education which should qualify them thoroughly as first assistants in emergency cases, and I would suggest that Dr. Smith, our Police Surgeon, should do his best to obtain a competent nurse, who could always accompany the ambulance.

It is almost presuming too much to read a paper on the subject of emergency cases to you, a body of well educated physicians and surgeons, but for such of you as may be interested I venture to say a few words as to what should be done, or perhaps better should not be done for such patients as are found in such places and under such conditions that they cannot be very thoroughly treated.

1. *Fractures* are generally sustained where they must receive emergency treatment. In order to reduce a fracture properly it is frequently necessary to administer an anaesthetic. If the fracture be compound, scrupulous aseptic or antiseptic treatment is needed. But it would be folly to attempt either of these on the street or in a factory or

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a shop where the air swarms with bacteria. Here I would recommend the careful removal of the clothes, the application of an antiseptic dressing, if compound, and a temporary splint to immobilize the broken bone or bones. Then get the patient to where he can properly obtain further treatment.

2. *Dislocations* may be reduced on the spot if reduction is easy; otherwise immobilize the parts well. Extreme caution is needed in dislocations as well as in fractures or dislocation of cervical vertebrae; no attempts should be made to reduce these, unless in the hospital or the patient's house, with assistants for anaesthesia, and so on at hand.

3. *Burns and Scalds* rank high as emergency cases, and are particularly frequent in railroad disasters; our first object being to exclude the air from the surface of the burn or scald, and this is best accomplished when the patient is in his home by placing the patient or the limb of the patient in a bath of bicarbonate of soda solution, or if such cannot be had, in cases of railroad accidents, by enveloping the burned part, no matter how much of the surface be involved, with sterilized cotton, such as you can always find at a drug store. A rather rare occurrence is the inhaling of steam with *scalding* of the mouth and throat, and perhaps a subsequent edema of the glottis. About twenty-five years ago I say such a case about six miles from town. I made a tracheotomy with instruments from my pocket case, made hooks of two hairpins, secured a free opening for respiration, and sent in haste for a tracheal cannula. I saved the child.

4. *Frost bites* are rare in our climate, and yet I have seen some cases. There is a great temptation to warm such frost-bitten parts, but this is the worst thing to do. The frozen parts should, if possible, be rubbed with snow, and the patient gradually be removed to a warmer place.

5. *Wounds caused by knives, swords,*

*hatchets*, and similar instruments, can be treated properly anywhere, with sterilized or antiseptic gauze. In this way the wound can be kept clean and if properly bandaged, the hemorrhage stopped.

6. *Hemorrhage from larger arteries* in the limbs, which require perhaps ligation should be controlled with a tourniquet, the handkerchief or Spanish windlass or rubber tubes or webbing (suspender), but great care must be taken that no lasting injury is caused by long continued pressure on the arteries. This pressure must be removed as soon as is possible to ligate. *Hemorrhage from nose* may be promptly arrested with a plug saturated with adrenalin; *hemorrhage from a wound on the head* by a compress. If such is not possible, by a pin placed under the bleeding vessel and compress or acupressure applied. Never attempt to suture a wound on the head without thoroughly cleaning and shaving, for there is no part as dirty and as prone to infection as the hairy scalp.

7. *Gunshot injuries*, unless there are fractures, rarely need anything more than protection from infection. It is a bad practice to probe a gunshot wound except under strict aseptic conditions. As a rule there is no need of it, the bullet itself has done all the damage it could do, and may remain in place until the case can be properly treated. The same may be said of *penetrating wounds caused by daggers*, or other stabbing instruments.

8. *Irreducible Hernia*. The shock resulting from an accident often deserves due consideration, and is sometimes of greater importance as an emergency factor than the injury itself. Be sure in such cases to have the head low; it is nothing difficult, even on the street to put the patient into a Trendelenburg position, and then use the usual remedies, as strychnine, adrenalin, etc.

10. A frequent occurrence is *Asphyxia* by gas, or in some industries by the damp air, in mines or vats. Such

cases must be promptly treated by artificial respiration in clear atmosphere (oxygen). In *Drowning* we have the same condition plus the water in the lungs. Here we must place the patient in such a position that the motions for artificial respiration will also assist in pumping out the water.

11. *Foreign bodies in the eye and ear* usually get into the hands of the specialists. *Foreign bodies in the nose* are frequently seen by the family physician. If they are large, as beans or rocks, and cannot be easily removed, allow them to remain until you are better prepared for an operation.

*Pins, needles and splinters* are frequent causes for emergency treatment. It looks so tempting to cut down upon and remove them, but if there is the

least doubt as to the location wait till you have an X-ray diagnosis, and then proceed.

*Poison cases* are always emergency cases, but I shall leave them to the medical department.

That terrible disaster of San Francisco has been a great chance for the display of good sense and judgment in emergency treatment, and I hope that the army of physicians who were then employed there have been well supplied therewith.

Surgical emergency treatment should be well understood by all who render first aid on the battlefield, by the ambulance men connected with hospitals; and no trained nurse can be considered efficient without a thorough instruction in such cases.

## EMERGENCIES IN OBSTETRICS—TREATMENT.\*

BY M. L. MOORE, M.D. PROFESSOR OF OBSTETRICS, COLLEGE OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA.

Without fear of contradiction I feel that I can assert that in no other department of medicine do the emergencies exist that require more prompt and scientific application of knowledge than in this important branch.

It is acknowledged to-day by all unbiased minds that the progress of the science of obstetrics has, as a review of its history will show—kept pace with other branches of medicines and that today it stands as probably more of an exact science than any of the other branches. I say this because we have only to glance over the different chapters of pelvic anatomy, embryology, of pelvimetry (which gives us the knowledge of the normal pelvis, and also positive and scientific reasons for doing certain operations in the different varieties of deformed pelvis) to realize this. This scientific development of obstetrics has been made possible by the better

understanding of the mechanism of labor and the different causes of dystocia, which has enabled us to so conduct labor as to save many hours of suffering and in many cases, of life itself.

To come to the subject of this paper it is difficult to decide what emergency is most important for it is not possible in the short time assigned us to do more than touch on some of the more common conditions.

Granted that an emergency exists, the practitioner to meet this emergency, must promptly recognize it and its causation and then by exercise of good judgment, apply his knowledge by stimulating nature's methods or by the prompt use of artificial means. In this way he saves life and thereby makes for himself a position among medical men: who are, I am glad to say, always quick to recognize true ability and give credit

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where credit is due, and on the other hand, I will say there is no profession more quick to condemn or more severe in their criticism than medical men are, of cases of mismanaged emergency work in obstetrics.

An emergency in obstetrics means that a life is in jeopardy, it may be the mother or child, or in some emergencies it may mean both mother or child.

Take for instance *hemorrhages*: We know from the anatomical arrangement of the muscular layers of the uterine and the vascular system of the uterus, that it is by contraction and retraction that hemorrhage is controlled. Take *accidental hemorrhage, concealed hemorrhage*. We diagnose the condition. What do we do then? We understand at once that we must empty the uterus to get retraction. Therefore we dilate mechanically the cervix, we do version and promptly deliver placenta and stimulate contraction. Take *post-partum hemorrhage*, one of the complications that oftentimes come unexpectedly. Here we have the uterus emptied, but we have a relaxation of the uterine muscles, a rapid filling of the blood-vessels, dislodgment of clots, and a hemorrhage from the placental site—that kills quickly. Still with the knowledge of the many causes of this condition we anticipate the occurrence and we at once stimulate the contraction and retraction of the uterine muscles and endeavor to maintain the same by artificial means. Take *post-partum hemorrhage* from deep tears of the cervix. Here contraction and retraction play no part in controlling it. We have the uterus well contracted, still the blood vessel bleeds and in the emergency that arises we do not hesitate, but act quickly and at once draw down the cervix and do what is indicated by, at once, with cat gut, putting in a through and through stitch, closing not only a laceration which would require a secondary operation if left unattended to, but controlling hemorrhage. Here nature is powerless

to control the situation and surgical or artificial means are employed with the prompt results of saving the life of the patient.

In another chapter of obstetrics we have the pathological condition of that most dangerous condition—*extra-uterine pregnancy*. Here the woman believes herself normally pregnant, all is expectancy and happiness, when as happens like a thunderbolt from a clear sky, the inevitable rupture comes, which in a few minutes renders her in condition of extreme shock from loss of blood into the peritoneal cavity, or in a lesser degree, if into the broad ligament. Fortunately in this situation we have as a warning of this most dangerous location of the ovary in many cases, certain symptoms which to the carefully trained and observing physician, cause him to investigate by physical examination and lead to the diagnosis of the unfortunate location. He at once, in the present light of surgical knowledge, removes by laparotomy the tube or ovary and saves his patient from the dangerous accident of rupture. In those cases, however, with the ovary in the fimbriated end we have, as I have seen in a few cases, no symptoms except those of normal pregnancy. Suddenly from an abortion through the end of the tube the patient drops to the floor and in a short time is in a condition of extreme shock. Here is an emergency in which delay means the death of a mother, while prompt surgical measures with which you are all familiar, saves her life. So I might go on considering other emergencies as those requiring forceps or version or those demanding prompt action in placenta previa, eclampsia, and so on.

In conclusion, let me say that emergency work in obstetrics to be well done makes it incumbent on every physician who practices obstetrics to constantly be on the alert and to be always ready with his armamentarium. He must act promptly, with courage and with skill and put into being such measures as are indicated by the conditions present.

## EMERGENCIES IN UROLOGY—TREATMENT.\*

BY P. NEWMARK, M. D., LOS ANGELES, CAL.

It is not my intention to discuss the whole broad subject of Emergencies in Urology, which is manifestly too large a theme, but to speak simply of two conditions which are of the utmost importance to the general practitioner, namely: One, Hemorrhages of the Urinary Tract, and Two, Sudden Absolute Retention of Urine.

## HEMORRHAGES OF THE URINARY TRACT.

The relief measures to be employed in the treatment of *hemorrhages of the urinary tract* can be divided into such that can be used in all cases, and such that vary according to the underlying causes leading up to the condition present.

Rest, application of ice and an internal hemostatic, especially Stypticin, can be used in all cases.

If these measures do not suffice, apply Adrenalin-Solution, either by means of instillation (1:1000) or irrigation (1:10000). Aside from these it will often be necessary to pass a catheter, which is left in place to check the bleeding.

The last means, which in cases of serious injuries must be employed first, is the immediate surgical procedure which consists of locating and stopping the bleeding.

In order to successfully cope with the various forms of hemorrhages, it is advisable to classify them, according to their etiological origin, into two principal groups:

1. *Hemorrhages independent of the act of urination.*
2. *Hemorrhages depending on the act of urination.*

The first group includes urethral hemorrhages resulting from *infectious diseases* and those *following injuries or surgical operations*. Among the hem-

orrhages caused by infectious diseases I should mention the severe gonorrhoeic inflammation, tuberculosis and incidentally, the polypoid excrescences of the urethra.

Rest, ice and Stypticin are the most important therapeutics in these cases; if necessary one may use instillation syringe with Adrenalin.

The hemorrhages of the urethra following injuries and surgical operations are usually more profuse, especially those resulting from traumatic rupture and gunshot wounds. If feasible, we should try to pass a catheter, which at the same time drains the urine and prevents infiltration of urine. However, in most cases of serious injuries, it becomes necessary to perform immediately urethrotomy externa, to tie the blood vessels and to drain the bladder from the urethral wound.

The most frequent cause for hemorrhages of this group, however, can be traced to the improper handling of metal catheters. Notwithstanding profuse bleeding, the majority of these cases terminate with a formation of a so-called false passage, provided we apply ice, Stypticin and abstain from any other manipulations upon the urethral canal. Should the bleeding continue, we may attempt the application of Adrenalin; if unsuccessful or in case of vesical irritability (tenesmus), pass an elastic catheter of large size to be left in place, and if bleeding still persists, do urethrotomy externa.

The second group of hemorrhages, those *depending on the act of urinating*, can be divided into such that precede the passing of the urine, such that follow it and those where the whole urine appears bloody throughout.

It is too little known that hemorr-

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hages *preceding the urinating* of old people are almost always due to the hypertrophy of the prostate. Mild cases of this kind should be treated with Styp-ticin alone, severer ones with Adrenalin, while the most profuse hemorrhages require the cystotomy with cauterization of the gland.

As an example of bleeding *following the passing of the urine*, I should mention the acute gonorrhoeic urethritis posterior.

The cases of *genuine hematuria* are with rare exception due to growths, calculi or tuberculosis of bladder or kidney, the nature and origin of which can only be accurately diagnosed by means of a cystoscopic examination.

In order to check hemorrhages of this kind, it will be necessary to treat the underlying condition which is responsible for the bleeding. However, the hemorrhage may become so profuse that relief measures must be resorted to immediately, which is best done by filling the bladder with 1:10000 Adrenalin solution. If this checks the bleeding, it is an indication that the hemorrhage originates from the bladder; if not, we may look to the kidney as the seat of the trouble and the cystoscopic examination will then determine which surgical procedure to adopt.

## II. ACUTE COMPLETE RETENTION OF URINE.

I shall now discuss the second part of my subject, the acute complete retention of urine.

The proper management of these cases is altogether dependent on the knowledge of the causes and of the question whether or not there is a mechanical impediment to catheterization.

For practical reasons, therefore, our subject may be subdivided as follows:

1. *Acute retention of urine without mechanical impediment*, and
2. *Acute retention of urine with mechanical impediment*.

Aside from central disturbances like apoplexy, traumatic injuries to the spine,

etc., there are only two causes which in men produce retention of urine without any mechanical impediment existing, namely: retaining the urine too long and the gonorrhoeic inflammation of the urethra posterior. In both cases the condition is due to a reflex-spasm of the sphincter-muscle. Hot baths, anti-spasmodic remedies like Belladonna and Opium will invariably relieve the trouble promptly, and only in exceptional cases will it be necessary to resort to catheterization.

The latter is indicated from the very beginning in those cases of retention, which we occasionally meet in hysterical women and in cases with acute inflammation of the pelvic organs. Anti-spasmodics are here of no avail, as the condition present is due to weakness of the detrusor-muscle and is easily relieved by catheterization.

The cases of acute retention of urine *with mechanical impediment* include:

In men: A. Abscess of prostate.

B. Stricture.

C. Hypertrophy of the prostate.

D. Traumatic Injuries to the urethra.

In women: A. Compression of the urethra by tumor, with or without the deviation of the urethra:

B. The well known retention on the first day post partum on account of the deviation of the urethra.

C. The retention during the first week post partum on account of the contusion of the external mouth of the urethra during confinement.

The least recognized of the above mentioned conditions is the acute suppurative prostatitis, the so-called *abscess of the prostate*, although its symptoms are very characteristic. The remedy *par excellence* is here the catheterization by means of a soft Nelaton or the Mercier catheter.

In order to relieve an acute attack of complete retention of urine caused by



urethral stricture, we proceed as follows:

We inject at first an ordinary urethral-syringe-full of Adrenalin-solution 1:10000 into the urethra, with the object of reducing the congestion of the mucous membrane near the stricture. We then introduce a filiform bougie and at the end of a small-sized metal catheter is screwed on, which is passed up into the canal while the bougie is coiling up in the bladder. After evacuation, it is advisable to unscrew the catheter, but to leave the bougie in place.

In the management of acute retention of urine due to *sudden congestion of a hypertrophied prostate*, we should consider the pathological-anatomical conditions, especially the lengthening of the prostatic part of the urethra, the deviation and narrowness of the canal on account of the hypertrophied tissue of the prostate. We should, therefore, use catheters, which are sufficiently long, curved upward and, if necessary, small-sized; at first, of course, the soft Nelaton catheter, which has the advantage of adapting itself to every shape of the canal. Next to the Nelaton, one should use the Mercier catheter, holding the beak precisely in the centre, with its concave surface upward, turning the beak to right or left only after it has reached the impediment of the enlarged prostate.

I should caution you against the indiscriminate use of metal catheters in the above mentioned cases, as the handling of these instruments requires great technical skill and is liable to give rise to profuse hemorrhages.

In cases of complete retention of urine, due to *traumatism* (traumatic rupture of urethra, gunshot wound) it will nearly always be impossible to catheterize and the only thing to do is the urethrotomy externa. However, in order to immediately relieve the painful condition and to prevent subsequent complications we should do *vesical as-*

*piration*, a procedure which ought to be adopted in all cases when catheterization fails and the further relief measures can not be carried out at once. This all the more, as vesicle aspiration very often has a decided therapeutic effect. Through removing the urine, it reduces the inflammatory condition present very materially and not infrequently renders a future attempt at catheterization more successful than the first one.

Regarding the question, how often a day we should catheterize a patient with complete retention of urine, I would say at least three times, but no more than four times. Should there be tenesmus, nevertheless, which can not be controlled by mild narcotics, I deem it better to insert a permanent catheter.

I should also emphasize the danger of completely and rapidly emptying a bladder which has long been used to its volume of residual urine.

In conclusion, I wish to state that the most rigid asepsis should be observed in the application of sound, catheter and cystoscope, as the application of these methods constitutes an operative procedure, from which a patient may suffer considerable damage. To relieve a patient of an urgent attack of retention of urine and to incidentally infect his urinary tract through unclean instruments, is rendering him a very poor service.

Of equal importance is the necessity of exercising the utmost gentleness in all our manipulations upon as sensitive an organ as the human urethra.

The late Vienna Urologist Ultzman was right indeed when he, in one of his lectures jestingly remarked:

"Wir können der Blase alles abschmeicheln, aber nichts abtrotzen."

Which translated into English, reads: "The bladder yields everything to cajolery, nothing to force."

The number of deaths from tuberculosis in England is 60,000 a year; yet it is said there are only 70 sanatoriums with room for 2760 patients.

## THE INTERNAL SECRETIONS OF CERTAIN GLANDS WHICH ELABORATE EXTERNAL SECRETIONS ALSO.\*

BY LYMAN BRUMBAUGH STOOKEY, PH.D., LOS ANGELES, CAL., PROFESSOR OF PHYSIOLOGY,  
COLLEGE OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA.

Claude Bernard was the first to emphasize the distinction between ordinary or external secretions and those secretions of glandular tissues which instead of being brought to the surface by a duct, are given directly into the blood or lymph-internal secretions.

Brown-Sequard in 1889 called attention to the possibility that not only may the ductless glands—the spleen, thyroid, parathyroid, pituitary, thymus, suprarenal—elaborate an internal secretion, but that all glandular tissues, whether they possess an excretory duct or not, may give off a “something” directly into the blood stream. This extended conception of internal secretion stimulated the carrying out of a series of investigations regarding the role of the internal secretions of those tissues which furnish an external secretion as well—the liver, pancreas, generative organs and kidney.

Usually the liver is not regarded as furnishing an internal secretion, yet some of the most important functions of this organ do not belong to its external secretion. Glycogen and urea are formed within the hepatic cells. Urea is not eliminated into the hepatic duct, but directly into the blood and therefore should be regarded as an internal secretion of that organ.

That the pancreas through its internal secretion has an important function in connection with the metabolism of carbohydrates has been recognized since the epoch-making discoveries of von Mering and Minkowski. However, the relation between the internal secretion of this organ and carbohydrate metabolism remained obscure until Cohnheim showed that while a freshly

hashed muscle alone is unable to oxidize dextrose, and a freshly hashed pancreas alone also is unable to burn sugar, if both are combined, sugar disappears rapidly. From this and extended experiments Cohnheim inferred that the pancreas furnished something in its internal secretion which has the power of making active the sugar splitting enzyme of the muscle. Pancreatic diabetes, according to these researches, is a deficient elaboration of this substance capable of activating the glycolytic enzyme of the muscles.

It has been known for some time that the testis and ovary furnish internal secretions which play important roles in metabolism. Gynaecologists have noted that ovariectomy often is followed by unpleasant mental and physical symptoms, and further that these symptoms can be ameliorated by the use of ovarian extracts. Menstruation has been proven to be due to the internal secretion of the ovary. The following experiments demonstrate the truth of this statement: First, if the nervous supply of the uterus and the ovaries is cut, menstruation takes place the same as before. Second, if the ovaries are removed, menstruation ceases. Third, if a small piece of ovary is grafted in any part of the body, the menstrual periods return.

Products of metabolism of the bit of grafted ovary are eliminated into the blood and stimulate the uterus. With the nervous supply of the uterus destroyed the only means of communication possible is the blood, and the necessity of the internal secretion of the ovary for menstruation is established. Recently Glass transplanted the ovary

\*Being a synopsis of a lecture before the sophomore class in physiology of the College of Medicine of the University of Southern California.

of one woman into another in whom complete ovariectomy had been performed two years before, and noted a return of menstruation and sexual desire and an amelioration of the unpleasant symptoms following the artificial menopause.

The function of the internal secretion of the ovary is not limited to a stimulation of menstruation. It is of common experience that complete ovariectomy often results in a tendency toward obesity which might indicate the absence of an influence of the internal secretion of this gland upon nutrition. That the ovary may exert a deeper influence upon metabolic processes seems to be supported by the frequent observation that in Osteomalacia the course of the disease may be alleviated through ovariectomy.

These clinical observations tending to show an influence of the internal secretion of the ovary upon metabolism were taken up recently from an experimental standpoint by Loewi and Richter. These investigators removed the ovaries from bitches and observed a marked decrease in the intake of oxygen. Further they found that the administration of ovarian extracts to these bitches restored the consumption of oxygen to the normal level, and that if larger doses were given the respiratory exchange could be raised considerably above the normal. Analogous results were obtained on castrated dogs after the administration of testicular extracts. These experiments of Loewi and Richter seem to afford experimental verification of the clinical observations cited above, that the ovary elaborates a spe-

cific substance or substances in its internal secretion which has or have to do with oxidative processes of the body.

Excision of a large portion of the kidneys was shown by Bradford to lead to a pronounced increase in the katabolism of the tissues. From these results it seems reasonable to conclude that the kidney through its internal secretion exerts some special influence upon the nitrogenous processes of the body. Tigerstedt and Bergmann succeeded in extracting from the kidney a substance which when injected subcutaneously produces a rise in blood pressure. These investigators found that the blood of the renal vein possesses this power of raising blood pressure while the blood of the renal artery does not. Their conclusion is that normally the kidney secretes something in its internal secretion which causes a vasoconstriction.

It may be of interest to note that the functions exercised by the internal secretions of the pancreas, ovary, testis and kidney, understood at the present time, seem to be fulfilled without the intervention of the nervous system.

These brief remarks should be sufficient to emphasize the great importance of the internal secretions of certain glands which we are so prone to associate in our minds, only or largely with external secretions.

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## THE TREATMENT OF FRACTURES.\*

BY W. W. RICHARDSON, M.D., LOS ANGELES, CAL.

The object of treatment in fractures of the long bones, is to secure consolidation in good position, with restoration of function. That is, to secure

complete anatomical and functional restitution in the shortest time possible and with the least inconvenience to the patient.

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Anatomical restitution of the bone and functional restitution of the limb do not necessarily go hand in hand, for no matter how accurately the form of the bone may be restored, the use of the limb is not regained, unless the soft parts and the joints, preserve their function and on the other hand a complete functional restitution may be achieved, with a very incomplete anatomical restoration of the bone.

A considerable degree of bony deformity is compatible with good function, if the deformity be of a certain nature. A marked degree of shortening may not interfere to any great extent **with the function**, and even some angular deformity in the shaft of a long bone, may not be of importance, provided that the general line of direction be not distorted.

This maintainance of the line of the bone is of the utmost importance, as upon it depends not only the leverage of the muscles, but of greater importance, the plane of the articular surface of the bone.

Any marked alteration in the plane of the articular surface will be followed by disturbance of the function of the joint. In children the continued growth of the bone will equalize to a great extent this deformity, as the growth of bone is in conformity with those laws which determine its natural form, but in adults this equalization takes place to a much lesser degree.

As a rule both anatomical and functional restitution should be striven for, but the greatest object of our treatment should be to restore, as far as possible, the function of the limb, with the least danger and inconvenience to the patient.

The first desideratum and the most important one, without which in most cases no good functional result can be obtained, is firm bony union.

To a certain extent, union of bone, as the healing of any other wound, is not under our control. We place the parts

in the condition most favorable for healing and we need do no more. In fact it is very difficult to prevent union where we wish to do so, wherever two raw surfaces of bone come in contact. Intervention of a foreign substance is about our only means, and this same factor is the most frequent cause of non-union in fractures.

Active or passive movement will not prevent bony ankylosis of a joint, denuded of its synovial membrane and cartilage, and motion per se will not prevent union of a fracture.

Absolute and permanent immobilization of a fracture as an essential for union has been much overrated. It is not possible, it is not necessary, and the attempt to obtain it has been the cause of great harm in the treatment of fractures. The fear of disturbing the callus has caused the fixed dressing to remain undisturbed when its removal while the callus was still soft, would have allowed of necessary correction of position, and prevented deformity, without in the least, interfering with the consolidation of the bone.

A callus is not like plaster of Paris, which will not set if disturbed. The formation of callus is increased by motion and its ossification not prevented, as we see for instance in rib fractures, where immobilization is impossible and yet pseudarthroses are extremely rare. In fact firm immobilization tends rather toward delayed or insufficient union.

We see this especially in fractures of the Tibia with no displacement, and few local symptoms, which have been put up at once in a fixed dressing, allowing little motion. Callus formation is slight and consolidation delayed. I believe this is one of the chief causes of the delayed union after operative resection in the continuity of the long bones, when the ends are wired together and the limb firmly immobilized. The healing is aseptic without reaction

and without stimulation of the periosteum to form callus.

That immobilization is not an essential in the treatment of fractures, Lucas Championnier of Paris has shown by his statistics of 1200 cases treated by massage and passive movement without attempt at mobilization by fixed dressings.

In Bardenheuer's clinic in Cologne, one sees no plaster of Paris nor other fixation splints. Every form of fracture is treated by extension with adhesive plaster and weights, and passive and active movements are begun early.

Recently he stated that he has treated in this way, in the last 20 years, 9500 fractures without one pseudarthrosis. His functional results are excellent, and though the confinement to bed is longer than by the fixed dressing treatment, the period of disability is usually shorter, as the function of the limb is restored almost as soon as the bone is united.

His technique is simple to understand when seen but difficult to describe, and probably for that reason has gained but little popularity in this country. The principle, as it appears to me, is simply that of placing the fragments as nearly as possible in their usual position, by extension and pressure with the hands, and then using adhesive plaster and weights to take the place of the hands. The position is always controlled by the Röntgen ray.

One striking thing in Bardenheuer's clinic is his manner of treatment of all fractures near the shoulder. All of these cases are treated by extension of the arm and forearm upward, usually perpendicularly, parallel to the median and frontal plane. In fracture of the clavicle, the arm is extended upward, outward and slightly backward. From the fourth day on, active movement in the shoulder is encouraged, and from the 14th to the 21st day gymnastics with a staff is begun.

His results by this method have been excellent, better, he says, than by any

other method. Fractures of the lower end of the Humerus, with great dislocation are treated by weight extension with the forearm in position of extension and supination. At the point of fracture additional cross extension is applied to overcome the angular deformity. In no other position than in extension of the forearm can the carrying angle be certainly preserved in severe fractures of the elbow.

In certain rebellious cases Graessner in Bardenheuer's clinic has applied the system of extension to the elbow with the forearm flexed to a right angle or beyond. These extensions in different directions seem very complicated when prescribed, but are quite simple when seen, and can be applied to suit any indication.

The extension treatment of fractures certainly fulfills all of the indications of treatment in most cases. The fragments are brought into apposition and retained in position, without danger to the limb, nor great discomfort to the patient. The fracture is accessible at all times to inspection, palpation and X-ray, and massage, and active and passive motion can be instituted early. The function of the limb is therefore early restored and the oedema stiffness of the joints and atrophy of the muscles, which delay convalescence so long, after treatment by immobilization in fixed dressings are avoided.

But the extension treatment is not the only way by which these undesirable conditions can be avoided.

The general principles of treatment are always the same, approximation of the fragments as accurately as possible, with retention in that position until consolidation has occurred, with as little interference with the function of the soft parts as is compatible with the retention in good position.

Putting up a fracture in plaster of Paris, immediately after the injury and allowing the cast to remain until consolidation has occurred, does not meet

these indications. I do not mean to derogate the treatment of fractures with the cast, for it is the method I most frequently use in fractures of the leg, but it must be used as any other method should be used with discretion.

It is not the appliance used, but the method of using the appliance, which determines a good or a bad result, in most cases.

In fracture of the Femur, for instance, good results can be obtained in many ways. Buck's extension and the long Hamilton splint, used correctly, will give the best of results, but the long Hamilton must not be bound tightly to the thigh, to act as an external splint, as is so frequently done, and as is advised in some works on fractures. It must be used as originally intended only to prevent the patient from sitting up and the foot from rotating outward. Coaptation splints are unnecessary in most cases, and may be harmful, by causing pressure atrophy of the muscles.

Again, in regard to the extension.

The amount need not be measured in pounds. It is not sufficient to hang on so and so many pounds and rest satisfied. Enough extension must be used to overcome the shortening and bring the fragments end to end. This need not be accomplished at once, but, gradually as the muscles relax. The Hodgkin's splint gives equally good results if applied correctly. As it gives the most comfort to the patient it is the method which I prefer, especially in fractures in the lower third, as a moderate degree of flexion of the knee is obtained.

Any degree of extension may be obtained, and I have several times had fractures heal with a centimeter lengthening.

The cast may be used in these fractures also, with excellent results, but great care is required. The ambulatory treatment of fractures of the lower extremity from the beginning, gives good

results in some hands, but I cannot speak of it from experience.

In fracture of the leg, after the second or third week, when all swelling has subsided and a new, well-fitting cast has been applied, allowing the patient to be up and about on crutches, favors callus formation, hastens recovery, and can do no harm.

In most fractures of the leg there is no hurry about fixation of the fracture. When great swelling is present or is to be expected from the nature of the injury, or in compound fractures with extensive injury to the soft parts, it is necessary only to place the limb in a position of ease, with sufficient support to prevent painful motion, until the swelling has subsided or the wounds are beyond the necessity of frequent dressings. A posterior splint of plaster of Paris, with the limb swung in a Hodgkin's splint answers all of these requirements.

This posterior plaster splint may be removed for dressings or massage, and the elevation in the Hodgkin's, aids in relieving the swelling, and affords more comfort to the patient, than any device I have ever used.

During this time, in simple fractures, hot fomentations may be used, and after the first day, gentle massage.

By the tenth or twelfth day the swelling has almost or quite disappeared, the effusion of blood has absorbed, and the active muscle spasm has subsided. As actual callus formation does not begin until this time, reduction is still easy, and in the absence of swelling it can be more readily controlled.

I have frequently noticed that the position of the fragments is better at this time than at the first dressing, chiefly, I think, from the relaxation of the active muscle spasm.

If reduction is not complete, it should now be accomplished under an anaesthetic if necessary, and a cast applied over webbing, with extra padding over



the malleoli and heel, the cast including the joints above and below the fracture.

After fourteen to sixteen days this cast should be cut, the leg removed daily, and massaged, and passive motion of the joints practiced. The callus is usually firm enough at this time to prevent displacement.

In the oblique fractures of the lower third of the Tibia, with tendency to displacement, a little more time may be given.

In compound fractures requiring frequent dressings I have often used the posterior plaster of Paris splint throughout the entire course, and although it does not immobilize completely, yet firm union takes place as readily as when more firmly fixed.

Operative interference in closed fractures of the diaphysis of the long bones, is very rarely necessary to secure sufficiently accurate opposition to insure a good functional result. The interposition of soft parts is about the only indication, and this cannot usually be diagnosed.

Absence of crepitus even where the fragments are freely movable is not an indication, as I have repeatedly seen fractures of the Femur, unite readily, in which no crepitus could be obtained. Comminuted or multiple fractures with the rebellious loose fragments will rarely require bloody intervention, but if good position cannot be obtained otherwise, there is no reason why we should not intervene operatively to replace and secure the fragments.

In fractures near or in the joints where exact anatomical restitution of the bone is more necessary to function, we should not hesitate to operate if satisfactory reduction is otherwise impossible.

Pressure of fragments upon vessels or nerves irremediable by other means, of course requires operative intervention.

The greater the resource of the sur-

geon, and the more versed he is in the mechanical treatment of fractures, the less often will the occasion arise for bloody intervention. In fracture of the patella and olecranon, however, if the separation is great, and if complete restitution of function is necessary, I think we should always operate if proper asepsis can be commanded.

In patellar fracture, the bone is not the most important factor. The amount of separation, and consequent disability is dependent to a much greater extent upon the condition of the lateral fascia of the extensors. Even absence of the patella will not interfere with extension of the leg, if the lateral fascia is intact.

In operating, therefore, not only should the patella be sutured, but the torn lateral fascia carefully united.

Where little or no separation is present and the leg can be actively extended, or held in extension unsupported, massage alone, without any retentive apparatus will give good results. In fact, a few surgeons have advocated this procedure in cases even with great separation and claim better results, with a greater proportion of bony union, than by fixation splints.

The rapid absorption of the effusion under massage and motion allowing the fragments to come into contact, and the absence of atrophy of the extensors being the explanation given for their favorable results.

I have used this treatment only in absence of separation, and prefer to suture where separation is great.

In the consideration of the general principles of treatment of fractures, I wish to emphasize the statement that the result depends not upon the initial reduction of the fracture, but upon the subsequent management of the case, which means retaining the fragments in position until consolidation has occurred, without interfering too greatly with the function of the soft tissues. Early massage and passive movement prevent atrophy of the muscles and stiff-

ness of the joints and favor rather than retard callus formation and consolidation. It is the future function of the limb which we wish to preserve, rather than its anatomical restitution, and they do not necessarily go hand in hand.

#### DISCUSSION OF DR. RICHARDSON'S PAPER.

DR. JOSEPH KURTZ: Had enjoyed the essayist's paper very much and agreed with him in the treatment advocated. It is true that in many fractures more is done than is necessary. If apposition can be maintained otherwise, there is no absolute necessity of splints. However it is to be remembered that some fractures do badly no matter how treated, and in such cases, not to have used splints, in this country at least, was simply inviting not only a malpractice suit, but in advance a judgment adverse to the surgeon. In the treatment of fractures, in America, we run across vicious patients and Dr. Kurtz recalled two such who persistently sought to induce displacements, in the hope of making a malpractice suit against him. Even with good function, if there was any anatomical deformity, one was liable to have a malpractice suit on one's hands, and the ordinary jury, it was to be remembered, so far as fractures were concerned, went largely by anatomical rather than by functional results.

As regards fractures of lower extremity it was Dr. Kurtz's practice to use extension and counter-extension with a Volkmann's splint, a splint that prevented decubitus and equinus. Only four weeks ago, a patient who had been treated elsewhere, came to me and seemingly sought my advice as an expert regarding a fracture in the upper third of the femur that had not been well treated although Dr. Kurtz did not tell him so.

Discussed the advantages of the Volkmann splint. Agreed with the essayist that massage was to be practiced early in fractures near joints if ankylosis was to be prevented. Had preached this for years. As essayist stated, there was little harm in slight occasional disturbances of the bones, and such disturbance would not prevent union, but these slight movements, through massage, would prevent ankylosis. Only yesterday a patient presented himself for an opinion on a fracture near the elbow, where ankylosis had resulted through lack of proper massage. Cited the case of a man, who with fractured femur and not suspecting the injury had been rubbed only with liniment by members of his family and who was out of bed in about three weeks, but who presented himself to Dr. Kurtz about three months later for deformity due to a callus as big as the fist. This case showed that the ends of bones would unite even under very adverse conditions.

Warned against circular plaster of Paris bandages. The plaster of Paris splint made by folding several layers of gauze one on top of the other, was a different proposition. A circular plaster of Paris bandage, later on, after three or four weeks, as a protection, was of course, allowable. Agreed with essayist as to but few patellar fractures needing sutures. Advised no incision lest sepsis ensue. In 1889 he had seen Volkmann's work in Holland and since then had used massage and with excellent results. The patellar fragments were kept in place by moleskin plaster fitted around the upper segment, so as to bring it down against its fellow. Had gotten excellent results from using this constant elastic tension in this way.

\* \* \*

DR. W. LE MOYNE WILLS: The impression that the treatment of fractures was as simple as confinement cases was an erroneous one. Emphasized Dr. Kurtz's remarks concerning the danger of malpractice suits if splints were not used. Spoke of Parkhill's method, also of another method which he had seen in Europe last summer, where absolute fixation was brought about by drilling holes into bones and fastening fragments. Intended to describe the method to the Association later on. As to fracture of the elbow joint, referred to Dr. Levi C. Lane of San Francisco, who used the long splint and early massage. Dr. Wills had gotten good results from that method. Last summer, in Liverpool, Dr. Wills had seen Robert Jones use over-flexion in fractures of elbow, on the principle that the triceps tendon is a split in itself.

\* \* \*

DR. F. C. E. MATTISON: Referred to a recent article by Dr. Murphy in regard to wiring the olecranon process.

\* \* \*

DR. W. W. RICHARDSON: In closing the discussion, stated that in 1902, Decq had written an article on the method recently advocated by Murphy. As to treating fractures without splints, in a mining community, where the miners were always anxious to sue the company, he had used only a Hodgkins' swing, with good results, and no malpractice suits. If no splint treatment applied to the femur, why not to the other long bones also? Supposed elbow fractures had been treated in every possible manner but no method gave better results as far as carrying angle was concerned, as did extension of the forearms.

An amputation for malignant ulceration should not be performed until the possibility of its being merely a broken down gumma has been satisfactorily excluded.

## "OUR WRONGS," A RESPONSE TO A TOAST.

BY W. B. SAWYER, A.M., M.D., RIVERSIDE, CAL.

Delivered at the banquet of the Southern California Medical Society, Arrowhead Hotel, Springs, May 3rd, 1906.

*Mr. Toastmaster, and Members of the Southern California Medical Society:*

There is perhaps no more deservedly unpopular citizen than the calamity howler. Yet he who is constantly prating of his wrongs and airing his grievances is quite apt to be one whose angle of vision is distorted. The doctor's wrongs are mostly fancied ones. In the profession pretty nearly every one gets what is his just due of success or failure, and the profession as a whole suffers no great wrongs for which it is not fairly accountable. The annoyances of unjust criticism, the attribution of false motives, the pitiful invectives of unhappy charlatans, and the copying competition of the quack are annoyances only, and our grand old profession scorns to account itself as in any sense a sufferer from a great wrong.

But within the ranks there is one class which suffers indeed, whose wrongs cry out for redress, but are inflicted not by the unregenerate heathen of the public, but by its false friends in the profession itself. Now the surgeon has no wrongs. He can't complain. He does not need to know much, and aside from a superficial smattering of anatomy and some facility with the needle and the knife, all he does need is to keep his hands clean and get a reputation. His diagnosis is made for him either post-operative or post-mortem, and the nurse takes care of his patient and his mistakes. He pushes the button, Murphy or otherwise, and Nature does the rest, and, while he is a jolly good fellow he feels his oats, struts a little, and is the cavalier captain of the gang of bandits who prey on the humble bedside practitioner.

In his company is the whole posse of "ologists," specialists in everything

imaginable, and not to be imagined. Microscopists, pathologists, diagnosticians, bacteriologists, each intent in his own way in taking away from the home-made hack doctor his patients, his fame, his courage, and the humble tools of his trade. The normal clinician honestly and carefully without any pretense or nonsense, examines his patient as a God-fearing doctor ought to. He looks at his complexion and facial expression, critically examines his tongue, notices if it is red, brown, furred or tooth marked; feels and notes his pulse; locates the region of his pain, palpates and percusses cavities, casually asks as to his excreta; and, without more ado, makes a proper diagnosis. What more can any sick man want in this line? Why, bless me, but this is the very perfume of the efflorescence of crass ignorance. See how it should be done:

First comes the blood-ologist; punches a hole in the man's ear; extracts a drop of blood; counts the corpuscles, finds two kinds of blood plates, three forms of plasmodii—some with and others without tails—and several organisms which he cannot name specifically, but which he is sure are closely allied to some other organism of much the same form, but somewhat different in reaction when treated with the same or slightly dissimilar reagents, or the same reagent similarly maltreated. Having arrived at this conclusion, and a "five dollars, please," the blood sharp lets go, and some other fluid-ologist gets the patient.

He finds somewhere a bacillus or something which is positive or negative to a "Gram" stain, and before he can give a definite opinion he must culture it. So he cultivates it a day or so, in agar, potatoes and soup; calls in an-



other friend, who recultivates the culture, measures the ultimate precipitate on a couple of guinea pigs, tests it on a cow, hands it back to the first, who thinks they are both rights, or both lefts, and the two solemnly report that it is not—though it ought to be—the *Bacillus Tremendosus*, and also say "five dollars, please."

Then the scopist steps in. Adjusting an eye mirror at the proper angle, he levels in the proper direction and through the appropriate media, an auroscope, a gastroscope, an endoscope, a cystoscope and a rectoscope, looks long and carefully, and when he has fully made up his mind which of the internal surfaces looks the worst, he makes his report, and with it, a "five dollars, please."

Then comes an all-round special Detector. He straps onto the patient a "some-kind-of-a-mometer," and gets the blood pressure; has him blow a spirometer, tests his grip with a gripometer, gets his electric nerve recoil, and finally winds up his X-ray machine, pulls out the stop for playing on internal organs, and finally takes a photograph to add to the collection of physical evidences of the symptom complex, and with this all goes a "ten dollars, please."

Now when the evidence is all in, and the patient finds that he has "non-tubercular recurrent appendicitis," how can the home-made doctor, who only found spasmodic inflammation of the bowels, ever expect to gain his confidence again?

When it comes to treatment, the trouble is just as bad. Did you ever stop to think of the advice given as to treatment in modern text-books? They are pretty much all alike. After going very thoroughly into the diagnosis, symptomatology, etiology, and so on, the author in a few lines takes up *seriatim* the old established medicinal agents, and proceeds to "knock" them,

and before he is through leaves you with practically the advice that you can do nothing, and that the case will die, anyway, "Unless suitable for surgical interference." So here comes Mr. Surgeon-General, armed cap-a-pie in apron, cap and gloves. He calmly removes, and proves thereby that they were entirely unnecessary, the appendix, colon, ileum, stomach, kidneys, gall-bladder, and in fact, every organ or part of an organ in the body, and if there is enough of the patient left when he gets through to cast a shadow, he is cured. He operates for diagnosis, for pain, for fun and for money, and is the picturesque knight of our science who has cast into profound and lasting obscurity the old-time internist.

But the few patients left by the surgeon can't be allowed to get well in the hands of the general practitioner. Along comes the specialist and claims his share of the loot. Eye, ear, nose and throat cases are whisked off to be specialized by those having "not only a special preparation based upon a special training and European travel for exactly such cases, but having procured at great expense all the necessary implements and facilities." And what a marvelous collection of mechanical contraptions they can produce. Nebulizers, atomizers, batteries with all kinds of electrodes and other "dingbats," enough to fill the old Curiosity Shop of Dickens.

The most wonderful of all of these is, of course, the X-ray machine, and when I explain to you what I fully believe will be its future usefulness and the scope of its application, judging from what I am told of its peculiarities now, you will agree with me that no so-called General Practitioner has any armamentarium left in comparison. I am creditably informed by some of my entirely reputable confreres that, aside from bringing out to the eye through the fluoroscope, the contour of the bones and

metallic foreign bodies lodged beneath the skin or in the cavities, that it cures lupus, produces great atrophic changes in various internal tumors, carcinomata, and sarcomata, relieves inflammation and produces sterility. Just at present these various possibilities are a little mixed, and this most intelligent machine is not altogether under control—not quite gentled and bridle-wise, so to speak. For instance, while trying to use the sarcoma-Ray, which, of course, in its search for the giant or spindle cells carefully avoids all else in the path, the operator cannot always avoid inflammatory and sterility rays, and trouble ensues.

But when it shall have been entirely broken to harness and saddle here is what we shall have: The lady approaches the operator; she states that she has a little too much embonpoint; the doctor has nothing to offer but a system of diet, and this she cannot undergo. The operator wishes to know whether "she will have her reduction of flesh full or medium?" "Medium, if you please." The operator pushes in the proper stop, sets the switch at medium, turns on the current, and, behold! she reduces to the very nicety of comfortable plumpness. Perhaps the lady will wish to avoid the duties incident to an additional increase of her family. The proper combination is arranged on the machine, and presto! she is immune. The converse is now, we believe, likely also to be true, and the tender blessings of the family may soon be obtained to order, one, two, three, as requested. But I will go no further into particulars to prove that the house-to-house bedside practitioner is being driven to the wall, and is soon to find his occupation gone. I feel sure that soon the classification of the Profession will resolve itself into Surgeons, Specialists and Midwives.

But, Mr. Toastmaster, turning aside now from these mental wanderings, for

myself I have no complaint. Next to my home I love best my Profession. From it, or any member of it, I have never received a wrong. It has fed and clothed me and mine for twenty-seven years. It has given me a higher mead of respect than any other calling could have done. It has shown me life in its broadest, highest and purest phases, and surrounded me with friends. Were I to live my life over again, I would choose to be no other than I am—a Doctor of Medicine.

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#### WHAT IS VERMUTH.

The following is a formula for the preparation of extract of vermuth:

Alcohol, 90 degrees ..	8.45 quarts
Coriander seed .....	12,344 grains
Nutmeg .....	3,086 grains
Greek nuts .....	3,086 grains
Cloves .....	1,543 grains
Ceylon cinnamon ....	1,543 grains
Peruvian bark .....	3,086 grains
Dittany .....	771 grains
Rose leaves .....	1,543 grains
Yarrow .....	2,777 grains
Hyssop .....	2,314 grains
Sweet marjoram .....	2,777 grains
Angelica seed .....	771 grains
Wormwood, sharp ...	11,109 grains
Roman wormwood ...	11,109 grains
Sweet flag .....	3,086 grains

After these drugs and herbs have been pounded and broken, they are infused in the alcohol for fifteen days, care being taken to stir the liquid each day. The above quantity of this extract, together with  $4\frac{1}{2}$  pounds of sugar and 11 pounds of glucose, may then be added to 85 quarts of white wine, and the result should be about 100 quarts of good vermuth.

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Surgical tuberculosis, no less than pulmonary tuberculosis, calls for the most careful general treatment post-operative and otherwise.

# SOUTHERN CALIFORNIA PRACTITIONER

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Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTINGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

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## EDITORIAL.

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### HOSPITALS AND SANATORIA.

There are few things in the history of modern medicine that are so gratifying as the growth of hospitals and sanatoria. That surgery to be successful should be aseptic meant a great development of the hospital idea, and this has gone on so rapidly that now even the public considers the hospital the place for surgical work.

There are also many medical diseases that would be more successfully treated away from home. We doctors are gradually coming to see that there is a large class of patients suffering from general diseases, including those afflicted with neurasthenic disorders, that ought to be sent to some institution or somewhere away from home where they can have the seclusion and rest that cannot be had in private houses.

It is reason enough for sending them away from home that these people can be more successfully treated when among strangers, but it is also true that the physician by taking this course would not infrequently keep a family, that otherwise might leave him in the search of help for an invalid member.

There are many people with chronic ailments who go from one physician to another in quest of relief, and each one is liable to leave the last physician with a new crop of symptoms, and a feeling of disappointment that does the doctor's reputation no good. These people should be sent from home, not for travel, nor for a brief rest, but for a stay of weeks or months in some institution where they are in expert hands. They need rest and treatment, but many of them need more than this, to be taught how to live.



Gastro-intestinal disorders we now know are common causes not only of functional nervous disorders, but are also the source of many organic diseases, and to prevent the development of these secondary results often requires a systematic and prolonged course of treatment that can be best carried out away from home. Of course the Sanatorium idea can be abused and physicians need to discriminate between those that are managed for the good of the patients and those that are conducted for "revenue only," but the principle is a correct one, and there is no part of the country better adapted to the development of this class of institution than Southern California.

#### A MUNICIPAL ABATTOIR FOR LOS ANGELES.

The startling revelations concerning Chicago Packing Houses, which have recently been occupying so prominent a place in the public press, have brought up the pertinent query in every part of the country, "How much of this unfit meat has been coming to us?"

Here in Los Angeles the Health officer, Dr. L. M. Powers, has been striving for years to obtain a more thorough supervision of our meat supplies, and on page 139 of the March PRACTITIONER of this year, was given a consideration of his efforts. Recent events have centered renewed attention and interest on the subject, a subject intimately connected with the public health of every community.

The Board of Health of Los Angeles and Dr. Powers are in favor of a municipal abattoir, to be owned by the city, where licensed butchers would be per-

mitted to slaughter inspected animals, at a cost sufficient only to defray interest and deterioration charges on the plant. In such a municipal slaughter house, stringent cleanliness would be insisted upon and all diseased meat could be prevented from reaching the market. The price of meat need be in no manner advanced, since the slaughtering expenses would be no greater than under the system of non-license and non-inspection.

Such a municipal abattoir is no new suggestion to Los Angeles, for as early as February 28, 1855, the Common Council of Los Angeles, passed an ordinance "regulating the conduction of a city slaughter house or corral and requiring a monthly fee or rental for the use of the same and the disposal of the offal in such a manner as not to be offensive."

And in 1893, the Board of Health, consisting of Doctors Granville MacGowan, W. W. Hitchcock, Joseph Kurtz and C. F. Gillingham created the office of meat inspector, and under the newly elected health officer, Dr. Powers, the system of meat inspection was inaugurated, which system Dr. Powers has constantly striven to improve.

New Orleans, Cleveland and other cities, both at home and abroad, have successfully operated such municipal abattoirs for some years. The plan is not an experiment. The Board of Health and health officer of Los Angeles are prepared to present a proper ordinance to the Council if there is any prospect of its passage. Nothing will create that prospect so much as public sentiment properly exercised. It is to be hoped

that while the iron is hot and the subject on the minds of all, the blow will be struck that will place Los Angeles in line with the other cities that have successfully grappled with and solved this problem.

### THE OPEN WINDOW PROPAGANDA IN TUBERCULOSIS.

In the London Letter of the *Journal of the A. M. A.* of May 26th, is an item telling of the efforts of some English phthysiologists to bring into being an organization that would spread the propaganda of the open window among the people of that country, but especially among the poor. This society, with this unique purpose, owes its origin to the belief held by phthysiologists that one of the most powerful of all factors in the prevention of tuberculosis is a constant supply of pure air and that pure air in houses means attention to proper ventilation.

Recognizing the lethargy of the poor of England, these phthysiologists have determined if possible, to overcome this indifference, by the wide-spread exploitation of the doctrine of the open window. They will seek to enlist in their work all who are interested in the prevention of the great white plague. Already many prominent men, lay and medical, have given the movement their co-operation. The membership dues will be spent for the publication of pamphlets which will have for their purpose the education of the public on matters of hygiene and sanitation, as well as for the development of a sentiment that will demand proper building laws.

The movement, which seems a logical

and feasible one, should meet with success.

### THE LOS ANGELES POST-GRADUATE SCHOOL, A NEW DEPARTURE IN MEDICAL EDUCATION IN THE SOUTH-WEST.

On July 1st the first summer session of the Los Angeles Post-Graduate School will begin. This new departure in medical education starts out under most auspicious circumstances. The size of the city of Los Angeles, the well-trained practitioners and able teachers, the large amount of clinical material in the various hospitals, the excellent buildings and equipment for teaching medicine and surgery, and the need of the Great Southwest for a high-grade post-graduate school, all amply warrant the establishment of this new institution. Los Angeles is the natural trade, social and educational center of the southwestern portion of the United States, and other things being equal, it is the city toward which the practitioners of a large part of the Pacific Slope and old Mexico naturally look, when they contemplate post-graduate work.

The Los Angeles Post-Graduate school will have at its disposal the well-equipped buildings of the College of Medicine of the University of Southern California, which represent an investment of more than one hundred thousand dollars. Soon, also, the splendid Barlow library building will be ready for use. In addition to the exceptional outdoor clinics among the Mexicans, and other citizens, the Post-Graduate School will have unusual opportunities for clinical and operative demonstration at the County, Sisters' and Receiv-

ing Hospitals, and at the Barlow Sanatorium. As the students of the school will be graduates of medicine, opportunity will be given them to witness operations by members of the staff in the excellent private hospitals of the city. At the Receiving Hospital matriculates will have an opportunity of witnessing and assisting in emergency operative work.

The faculty of the College of Medicine of the University of Southern California will be identified with the Post-Graduate School, largely in an advisory and consulting capacity. The members of that faculty, whose work in teaching during the last two decades has exercised a most potent influence on the medical profession of the Southwest, will therefore be at the service of and in full sympathy with the work of the Post-Graduate School. The teaching staff of the school contains the names of many prominent practitioners of the city, and their aggressive and successful careers in private practice will be marked no doubt, by equally good results in educational work. The clinical teaching of the school will be at the hospitals already mentioned, and at the College of Medicine dispensary. Special lecture and laboratory courses will be given at the college buildings. Quiz courses for those who desire to prepare for the California State Board of Medical Examiners will also be given.

The scope of the school is therefore laid on broad foundations, and the work will be in line with the highest and most modern requirements and standards.

The officers elected by the faculty of the school are:

Dr. W. Jarvis Barlow, *President*.

Dr. E. W. Fleming, *Vice-President*.

Dr. W. W. Richardson, *Secretary*.

Dr. John C. Ferbert, *Treasurer*.

Those who are interested in the work of the school can receive catalogues outlining the courses in detail, by addressing the Secretary, Dr. W. W. Richardson, Bradbury Building, Los Angeles.

#### A COURTEOUS ACT.

The records of the California State Board of Medical Examiners, and likewise those of the California State Pharmacy Board, were both destroyed by fire in the San Francisco cataclysm. Such a misfortune, if left unremedied, would have seriously handicapped each of these boards in their future work.

The State Board of Pharmacy, of which Mr. C. T. Off is the president, immediately determined to apply for an appropriation from the State Legislature for the restoration of its records.

The President, Secretary and Treasurer of that board were early on the ground at Sacramento, and knowing that the Medical Examiners' records had been totally destroyed, and finding that the Medical Board was not represented, petitioned the Legislature for an appropriation of \$4500 for each board, to restore their respective records. Later the Board of Medical Examiners seconded this request.

As a result of the faithful effort of the Pharmacy Board officials, each board received an appropriation of \$2500.

For this courteous thought and action



the California State Board of Pharmacy deserves and has the appreciation and thanks of the medical profession of California.

#### **A REVISION OF THE BUILDING ORDINANCES OF LOS ANGELES.**

The building inspector of Los Angeles, in conjunction with several architects and insurance underwriters, at the request of the Common Council of the city, visited San Francisco shortly after the earthquake and fire, and as a result of the observations and knowledge there acquired, presented to the Council certain amendments to the building laws of Los Angeles.

These amendments have for their purpose the prevention of destruction of property and life by either earthquake or fire. The amendments have to do especially with the height, thickness and general construction and material of walls, and particular attention is given to the proper anchorage of chimneys, fire and other walls and partitions that rise above the surface of upper stories.

The suggestions and proposed amendments have been duly ratified by the Council, and what little danger Los Angeles may have chanced to have been in the past, from its supposed location in a so-called earthquake zone, bids fair now to be entirely minimized or neutralized.

It may therefore be said that Los Angeles has profited by the misfortune of San Francisco in that that city's awful experience has led to the adoption of building requirements in Los Angeles which ordinarily would have had little or no chance of passage.

If these requirements are faithfully enforced, and if the insurance underwriters raise their rates on defective buildings, there is little doubt but that these amendments may be made to apply, not only to new, but to old buildings. For rather than pay excessive insurance rates on defective structures, landlords will make such changes as will remedy defects and place their buildings in a safer class.

It is evident, therefore, that these new amendments of our building laws will be of decided benefit to the city of Los Angeles.

#### **THE WAY TO COMBAT THE PATENT MEDICINE EVIL.**

The Honorable Champe S. Andrews, Legal Counsel for the New York County Medical Society, recently delivered before the Philadelphia Society of Medical Jurisprudence, an address (see *Journal A. M. A.*, May 26th) on the above subject, which is a noteworthy contribution to a topic now occupying the attention of both the lay and medical press.

Mr. Andrews, owing to his large field in New York city, has had exceptional opportunities to study the evil and far-reaching effects of patent medicine charlatanism, and his words are therefore worthy of careful consideration.

His plan in brief is to organize a Society for the Preservation of the Public Health, which would seek the co-operation of all professional and philanthropic organizations, lay or medical, having at heart the conservation of the public health. In addition he would seek to enroll all persons interested in

the work who were not identified with such organizations.

He points out the splendid organization of the patent medicine manufacturers and charlatans, and states his belief—founded on extensive observations—that organization must be met with organized opposition if the patent medicine evil is to be overcome.

The address is full of pertinent suggestion and thought. We quote only one paragraph bearing on the relation of our own profession to this evil:

"The physician has led the way in this work because of his public-spirited interest in it. The physician, more than anyone else in the community, realizes the dangers of quackery, and he has tried to suppress it because as a physician he feels it his duty to relieve suffering wherever he can. But the physician cannot fight the evil single-handed. The physician has been fighting our battle, the battle of the public, for an hundred years and more, and it is time for the public to rally to the support of the common cause.

"Medical men would no doubt take a leading part in the activities of the proposed society for the preservation of the public health, but they should not be

expected to do it all. At least 50 per cent of the membership in the proposed society should be laymen of influence and standing in the community."

Personally this address of Mr. Andrews is of more than passing interest to us in that our acquaintance with him began more than a decade ago when we were both youngster delegates to a college fraternity convention. The son of a Confederate Colonel and himself a captain of a Tennessee troop in the Spanish-American war, this ambitious Southern boy went to New York to practice law, because, if the opposition was greatest and the struggle was hardest there, the rewards, in case of success, were correspondingly large.

A young man, in the early thirties, he took up his work as counsel of the New York Medical Society with enthusiasm and vigor, and it was largely his successful prosecution of quacks and his startling statements before the New York Courts, that led the press of the metropolis and later the lay periodicals to take up the campaign against patent medicines.

His career should be an incentive to young men as showing how work faithfully performed in the duty nearest at hand, will bring its adequate rewards.

## EDITORIAL NOTES.

Dr. J. A. Chiapella has located in Hollywood, Cal.

Dr. J. S. Trehwella has located in Whittier, Cal.

The Whittier Hospital was opened in the city of Whittier on June 4th.

Dr. O. V. Fitzsimmons has located in Globe, Arizona.

Dr. R. E. L. Sevier has relocated in Monrovia, Los Angeles County.

Dr. W. Jarvis Barlow is traveling in Alaska.

Dr. D. W. Mott of Santa Paula has been visiting in Washington, D. C.

Dr. James A. Jackson has been elected Health Officer at San Jacinto.

Dr. Harry M. Smith and Miss Jessie Hield were married at Las Vegas, New Mexico, on Saturday, May 12th.

Dr. Benj. Bakewell has located for

the practice of medicine at Santa Barbara.

Dr. C. E. Yount of Prescott, Ariz., has been in attendance at the American Medical Association at Boston, Mass.

Dr. Jesse Chilton of Fullerton, Cal., was married to Miss Grace Fridd, Berlin, Wisconsin, on June 2nd.

Seventeen women graduated from the Los Angeles County Hospital Training School on the evening of June 5th. Addresses were given by Drs. D. C. Barber and J. Lee Hagadorn.

Dr. J. Percy Lewis of San Diego is spending a few weeks in Chicago devoting himself to post-graduate, eye, ear, nose and throat work.

Dr. Kate Wilde has returned from her trip around the world and is now located at 747 Crocker Street.

Dr. H. H. Koons of Tombstone, Arizona, was recently called professionally to Tucson.

The Training School of the County Hospital of San Diego graduated four nurses on the evening of June 5th. Dr. David Gochenauer delivered the address.

Dr. Norman Bridge has returned from England. He was there when the news came of the San Francisco earthquake, and says that the Britishers were greatly interested.

The second public sale of quinine in Java for the year 1906 was held in Batavia on March 28th. Several thousand pounds were sold at \$5.19 per kilogramme.

A class of four women were graduated from the Riverside Hospital Training School on the evening of June 1st. Dr. C. Van Zwalenburg made the principal address.

The Long Beach Medical Association held its regular meeting on the evening of May 30th, at the office of Dr. J. W. Wood. After a paper by Dr. Wood, entitled "Prostatic Inflammation," the

meeting closed with a delightful banquet.

Dr. James P. Booth is now located in his suite of rooms in the Mason Building, corner Fourth & Broadway, Los Angeles. His 'phones are Main 2035, Home 5967. His residence phone is Home 8370. Dr. Booth gives special attention to the administration of anaesthetics.

The physicians of Santa Monica are planning to build a one-hundred-thousand-dollar hospital. J. C. Austin, the Los Angeles architect, who has made a special study of hospitals has been engaged as the architect. Dr. S. W. Smith of Santa Monica is taking a leading part in the enterprise.

Dr. Julian Carroll Kendrick of Anaheim, Cal., died on May 31st, after practicing medicine in Los Angeles County for twenty-five years. He served for two years in the Confederate Army. He was a devoted member of the Christian Church, and was an upright citizen and a good general practitioner.

Dr. G. W. Compton of Ophir, Colo., writes that he desires to sell his practice which amounts to \$3000 a year and his home, in a prosperous Rocky Mountain Camp, all for \$2500 cash. Any physician looking for that kind of a location would do well to correspond with the Doctor.

The Cutter Analytic Laboratory had their San Francisco offices burned, but their laboratory building and reserve stock in Berkeley were uninjured, and their head offices have been established on their laboratory premises, so that they are ready to supply all demands, the fire not having interfered with their business at all.

The College of Physicians and Surgeons of Los Angeles held their commencement exercises on June 7th. Addresses were made by Prof. Charles W. Bryson, dean of the faculty, Prof. J. H. Seymour, president of the board of trustees, and others. There were three



graduates, namely, Samuel Burgess Richardson, Rokuro Koharu and Frank Forrest Barham.

American doctors desirous of obtaining licenses in Japan must first become residents of Japan. Their applications must be accompanied either by diplomas from responsible medical colleges or licenses from their own government. Upon receipt of such application the government will investigate the character and standing of the applicant as well as that of the college or the nature of the license from the foreign government, and if found satisfactory will grant the license. Such investigation usually takes about six months.

The Cleveland Press, Chicago, is about issuing a work by Dr. Albert J. Ochsner, surgeon-in-chief of the Augustano Hospital and professor of surgery in the Medical Department of the University of Illinois, Chicago, and Meyer J. Sturn, a well-known architect of Chicago, the title of which is "The Organization, Construction and Management of Hospitals." From what we see of the announcement we believe that this work will fill an important demand. This is an era of hospitals and a comprehensive work like this is much needed.

The commencement exercises of the Pasadena Hospital Training School for Nurses were held May 24, 1906, at the Shakespeare Club House in Pasadena, the graduating class consisting of six members. The programme of the evening included addresses by the Rev. Wm. MacCormack, Dr. W. Edward Hibbard and Judge E. Willit.

Owing to the high price of beef and mutton in the German empire, horse and dog meat are becoming popular. In the first three months of 1905 35,066 horses were killed in the German Empire to be sold in the markets for food, while in the fourth quarter of 1905 the number of horses eaten was 52,584. In several sections of Germany there are

two, three and four times as many horses slaughtered for food as steers. Dog meat is becoming steadily more popular, but we have not the exact figures as to the number of dogs slaughtered for food, except that in all of Prussia there were 526 dogs, in Bavaria 181, and in Baden 3 dogs slaughtered in the last quarter of 1905. A German paper says: "Hence it will be seen that our nation's food depends more and more on the dog."

Dr. W. J. Galbreath, the American Consul for Cananea, has been having a warm time in that Mexican town.

On Wednesday night, May 30th, in their camp near Marshall's Lake, Arizona, Mr. and Mrs. Thomas C. Freyer while sleeping were bitten by a skunk. Mrs. Freyer was bitten on the right cheek, and the animal had to be pulled away by Mr. Freyer who was bitten on the left hand. They went to Flagstaff and left the next night for the Pasteur Institute, Chicago, for treatment for hydrophobia. The skunk which bit them was captured and taken to Chicago. It is not known to be what is called a hydrophobic skunk, and it is hoped that this may be determined at the Pasteur Institute. On the following Friday night E. J. Fuller of Pine, Gila County, while on his way to Flagstaff was bitten on his right hand by a skunk. The animal was caught and killed. Whether the skunk was of the hydrophobic kind was not known, but Mr. Fuller decided he would take no risk and left Monday for the Pasteur Institute for treatment. In the past a number of persons have been bitten in Arizona by skunks, and in a number of instances those bitten died of hydrophobia.

The following item, with the heading: *'Bad Medicine Almost Fatal. Patent Stuff Nearly Kills a Long Beach Man. He Takes a Dose of It to Relieve Pain and Is Afterward Found Unconscious by a Woman Who Enters His Store—*

is taken from the *Los Angeles Times* of June 7. Comment is unnecessary:

"Taking a dose of patent medicine to relieve the pain caused by an attack of cramps almost resulted in the death of John Meyers, proprietor of a confectionery, at No. 123 American avenue, this morning.

"About 10:30 o'clock a woman living in the neighborhood entered the store and found Meyers lying unconscious on the floor. Fortunately the woman had had training in hospital work, and after applying first aid measures she sent for

medical aid, and continued her work until the physicians arrived. After an hour's heroic treatment the victim was aroused from his heavy sleep. Then it was learned that he had taken a dose of patent medicine to relieve an attack of cramping, and in a few moments felt himself losing consciousness. He attempted to get to the door to call for help, but fell. From the symptoms the physician says the medicine contained laudanum and opium. This afternoon Meyers is resting quietly, and is believed to be out of danger."

## MISCELLANEOUS.

### THE COMMENCEMENT EXERCISES OF THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

The graduation exercises of the eighteenth class of the College of Medicine of the University of Southern California were held at Simpson Auditorium, on Thursday evening, June 14th. The annual banquet of faculty, alumni, graduates and invited friends, was held on the preceding evening at Levy's.

#### THE BANQUET.

After doing justice to the menu which Levy placed before the several hundred medical men who sat down at the banquet board, Dr. Walter Lindley, the President of the evening, introduced the toast-master, Dr. George L. Cole. The complete toast list was as follows:

DR. WALTER LINDLEY

President of the Evening.

DR. GEO. L. COLE

Toastmaster.

A Sister's Point of View.....

.....Miss Isabell Crowell

Why a Post-Graduate School....

.....Dr. W. W. Richardson

The Medical Student as an Object of Reverence....Dr. Joseph Kurtz  
Idiosyncrasies of Celebrities.....

.....Dr. F. M. Pottenger

The Doctor as Viewed by a Lawyer

.....J. D. Fredericks, Esq.

Duet.....Messrs. Ball and Barnhart

The after-dinner talks, which were much enjoyed, came to a close just before the midnight hour.

#### THE COMMENCEMENT EXERCISES.

The graduation exercises of the class of 1906 were held at Simpson Auditorium, the following programme being carried out:

Overture.

Invocation.....Rev. B. C. Cory  
Music.

Address....Rt. Rev. Thomas J. Conaty  
Bishop of Monterey and Los Angeles.  
Music.

Presentation of Graduates by Dr. Walter Lindley, Dean of the College of Medicine, and Conferring of Degrees by Dr. George Finley Bovard, President of the University of Southern California.

Music.

Announcement of Internships and Prizes.  
 Music.  
 Benediction.....Rev. B. C. Cory  
 Music.

#### THE GRADUATES.

The class consisted of the members named below, and the best wishes of faculty, alumni and friends go with them in the responsibilities which they are about to assume in the larger world outside of college walls.

John Taylor Ball.  
 Sidney Albert Bristol  
 William Barnhart.  
 Isabel Crowell.  
 Harry Hoag Chamberlain.  
 Francis Belmont Dwire.  
 Charles William Decker.  
 Henry William Dudley.  
 John Ellery Fates.  
 Fred Durfee Fairchild.  
 John Rollin French.  
 David Carl Farnsworth.  
 George Alexander Knox.  
 Elmer Frederick Kinnie.  
 Cory Childs Ledyard.  
 Eugene Graham Mattison.  
 Jay Sheridan Mebarry.  
 Thomas William O'Reilly.  
 Carl Elton Phelps.  
 John Thomas Peery.  
 John William Reed.  
 William Walter Sherer.  
 Harvey Smith.  
 Walter Carl Smiley.  
 Harold Alvin Thompson.  
 William Almon Wood.  
 Albert Henry Winter.

#### THE PRIZES.

After the delivery of the diplomas it was announced that the following graduates had received hospital appointments: Isabel Crowell, Children's Hospital, San Francisco; Harry Hoag Chamberlain, County Hospital; Francis Belmont Dwire, County Hospital; Charles William Decker, California Hospital; John Rollin French, California Hospital; Elmer Frederick Kinnie, Sisters' Hospital; Cary Childs Ledyard, County Hospital; Eugene Graham Mattison,

County Hospital; Elmer J. Patten, Santa Fe Hospital.

Two prizes offered by Dr. W. Jarvis Barlow to the graduates of the class were also announced.

The senior prize of \$100 in cash, given to the senior having the highest average for work in the junior and senior years was awarded to Miss Isabel Crowell of Alhambra, the only young woman in the class.

E. F. Kinnie and C. W. Decker received honorable mention.

The sophomore prize of \$50 in cash, awarded under the same conditions, was given to S. W. Hastings. P. E. Simonds and A. C. Macleish received honorable mention.

#### EIGHTH ANNUAL COMMENCEMENT OF THE SCHOOL FOR NURSES OF THE CALI- FORNIA HOSPITAL.

The eighth annual commencement of the School for Nurses of the California Hospital was held on Thursday evening, May 31st, at Blanchard Hall, which was beautifully decorated for the occasion, the following young women receiving diplomas:

Miss Minnie Allen, Los Angeles, Cal.; Miss Carolyn Arnold, Portland, Or.; Miss Ruth E. Arnold, Portland, Or.; Miss Inez Gayle Blackledge, Pomona, Cal.; Miss Edna Carter, Anaheim, Cal.; Miss Margaret Henze, Los Angeles, Cal.; Miss Katherine McKay, Saticoy, Cal.; Miss Sue C. Miller, Los Angeles, Cal.; Miss Pauline M. Sudow, New York City.; Miss Gertrude Tucker, Sierra Madre, Cal.; Miss Ida Westover, Indianapolis, Ind.; Miss Margaret J. Willis, Etiwanda, Cal.

The programme of the evening was as follows:

Music—Arend's Orchestra.  
 Invocation—Rev. Wm. S. Young.  
 Music—Arend's Orchestra.  
 Address—J. D. Fredericks, Esq.  
 Music.  
 Address on behalf of the faculty—M. L. Moore, M.D.



Music—Arend's Orchestra.

Delivery of diplomas—F. T. Bicknell, M. D., President Board of Directors.

Music—Arend's Orchestra.

The flowers presented to the fair graduates were many and beautiful, and with the white costumes of the class formed a most pleasing stage setting.

Captain J. D. Fredericks, Dr. Melvin L. Moore and Dr. F. T. Bicknell in their addresses to the class and audience gave not only a large amount of wholesome and valuable advice, but tinged it with considerable humor.

After the exercises at Blanchard Hall, the graduates and their friends in the audience adjourned to the Wise residence, adjoining the nurses' home of the California Hospital on South Grand avenue, and there, to the music of Arend's Orchestra, the remainder of the evening was spent in dancing.

munal and provincial governments, but also of the Central government itself. All are making efforts to save the workingmen from its effects. It is said that it was brought originally into Belgium by Italian laborers who had worked in the St. Gothard Tunnel. It first attacked the Belgian coal miners about 1894 and assumed an epidemic character which threatened to be widespread in its consequences. For a time it seemed to lessen, but again broke out afresh. In 1899 the provincial medical board organized a system to eradicate, if possible, or at least to prevent its further spread throughout the Province of Liege. While it is commonly known as a disease special to miners, it is also known that persons working in a warm and humid atmosphere, with little ventilation and no attention given to cleanliness, have been also stricken.

#### CAUSE AND PREVENTION.

The ankylostomes that cause the disease are small worms that attach themselves leech like to the bowels and suck in the blood. The person afflicted becomes weaker daily and grows anaemic. His face becomes pale, his breathing labored, his heart palpitates rapidly, and he suffers from severe stomach pains. If prompt action is not taken the case often proves fatal. Sanitation, as perfect as it can be made in the coal mines, is necessary to retard the progress of this disease. Retiring places, separate from the immediate place of work, are now established in every mine, and the failure of a workman to comply with the regulations appertaining thereto will be met by instant dismissal. This is regarded as a most important safeguard against the disease. The workingmen are admonished not to drink the water found in the mine, but to use only such as comes from the surface. They are also instructed not to eat anything from their hands or to allow any part of the hand to come in contact with the mouth until the

#### ANKYLOSTOMIASIS—EFFORTS TO ERADICATE A DREADFUL DISEASE.

Consul McNally, of Liege, reports that the Belgian government is giving a good deal of attention to the dreadful disease that has done a great deal to increase the mortality among miners. He writes:

The unique ailment, called by the Belgian doctors ankylostomiasis, has grown into such importance that tables and records of the disease formed an important space in the department of hygiene at the Liege International Exposition just closed. This department of sanitary science endeavored to show the origin of the disease, its development and consequences, and to point out the measures necessary to prevent its contagion, as well as the stringent regulations adopted by the authorities to stamp it out. Its ravages within the last few years have been such as to elicit the interest not only of the com-

hands are carefully washed. Upon observing the first symptom a physician must be called and the patient must follow explicitly the instructions given.

#### CO-OPERATION TO FIGHT THE MALADY.

The mine owners have heartily co-operated with the authorities to fight the malady which is a menace to the lives of the miners and to the industry itself. Pamphlets treating of the disease were printed and distributed among the workmen, lectures by competent authorities were delivered at the mines, and the provincial medical board issued practical suggestions to guard against contagion, while the minister of industry and labor organized a commission to revise the mining systems and to establish sanitary measures heretofore unknown.

Under the influence of the above the disease was checked, and every effort is being made to prevent its return. The mine owners established baths, hospitals, and dispensaries at the mines, while the provincial council includes, among its yearly appropriations, sums to be given to those suffering from ankylostomiasis.

The dispensary for miners was established under the auspices of the Provincial Institution of Bacteriology, composed of eminent physicians and chemist. Many public-spirited men gave various sums to help fight this disease. At the exposition, in the section mentioned above, a chart was arranged showing that at the mines of Mons and Charleroi 7 per cent. and 14 per cent., respectively, of the employes were afflicted. In the coal fields of Liege and Seraing (adjoining those of Liege) the disease was highly epidemic and the loss of life was great in comparison to the number afflicted. Herve, near Liege, suffered but little.

The various mines within the Province of Liege prepared diagrams of their sanitary installations, with photo-

graphs of the bathrooms, dressing rooms, and the system of shower baths. The history of the disease was plainly shown by the different mines affected.

#### NUMBERS AFFLICTED.

At the coal mine of the Nouvelle-Montagne Company, at Engis, near Liege, 75 per cent. of the underground employes were afflicted before the sanitary improvements were made. At the Gosson Lagasse mine 67 per cent. of the miners were suffering from the malady, and it was necessary for the company to go to great expense in removing conditions held responsible for its spread. All the larger coal mining companies readily acquiesced in the opinion of the provincial government board and instituted sanitary methods that have lessened the disease until now there are but a few sporadic cases.

The system employed by the local authorities is to isolate a mine where the disease is known to exist and to forbid the employment of any of its workmen until the same is pronounced free from disease. While shower baths have been placed in all the mines, about half of the workmen refuse to use them, which is considered a regrettable circumstance by the medical authorities. However, the malady has now almost disappeared, thanks to the energetic action of the provincial authorities and the hearty co-operation of the mine owners in making improvements as rapidly as they were suggested. If a miner becomes ill he is immediately placed in the company's hospital and remains under the doctor's observation until his ailment develops. Nearly all the mines within the province were affected and the proportion was from 25 per cent. to 75 per cent. of the underground workers.

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#### TOBIAS HOBSON.

"Hobson's choice" is an expression we often meet with in books or hear in conversation. - The origin of the phrase can-

easily be learned from No. 509 (Wednesday, October 15, 1712), of Addison and Steele's "Spectator," from which paper we borrow the following:

"I shall conclude this discourse with an explanation of a proverb, which by vulgar error is taken and used when a man is reduced to an extremity, whereas the propriety of the maxim is to use it when you would say, there is plenty, but you must make such a choice as not to hurt another who is to come after you.

"Mr. Tobias Hobson, from whom we have the expression, was a very honorable man, for I shall ever call the man so who gets an estate honestly. Mr. Tobias Hobson was a carrier; and, being a man of great abilities and invention, and one that saw where there might good profit arise, though the duller men overlooked it, this ingenious man was the first in this island who let out hackney-horses. He lived in Cambridge, and, observing that the scholars rid hard, his manner was to keep a large stable of horses, with boots, bridles and whips, to furnish the gentlemen at once, without going from college to college to borrow, as they have done since the death of this worthy man. I say, Mr. Hobson kept a stable of forty good cattle, always ready and fit for travelling; but when a man came for a horse, he was led into the stable, where there was great choice, but he obliged him to take the horse which stood next to the stable-door; so that every customer was alike well served according to his chance, and every horse ridden with the same justice; from whence it became a proverb, when what ought to be your election was forced upon you, to say *Hobson's choice*. This memorable man stands drawn in fresco at an inn (which he used) in Bishopgate street, with a hundred pound bag under his arm, with this inscription upon the said bag:

"The fruitful mother of a hundred more."

"Whatever tradesman will try the ex-

periment, and begin the day after you publish this, my discourse, to treat his customers all alike, and all reasonably and honestly, it will ensure him the same success."

#### MISTLETOE AS A CURE FOR ITCH.

"The trees . . . forlorn and lean,  
O'ercome with moss and baneful mistle-  
toe." (*Titus Andronicus*, II., 3.)

This mysterious plant, to which Shakespeare, in common with all older writers, applies an approbrious adjective, is extremely plentiful this year. Apple orchards in the West are heavily laden with the plant; but most of our mistletoe comes from the southern States. Those who lay claim to understand the ways of Nature, prophesy, from the profusion of its semi-transparent berries—those "pearls of Flora's jewelled crown"—a winter of unusual severity.

The mistletoe, by its curious mode of growth, was an object of reverent awe to the ancient Britons, especially when found growing on the oak, the favorite tree of their deity. Contrary to the common belief, the plant is very rarely found on this tree; it is found chiefly on apple trees and those allied to them. Not only did the plant inspire reverence among the ancients, but it was looked upon with a considerable amount of fear, for it was the plant accursed by the gods, and had the power of working evil upon the earth. Balder, the fair god of peace in Scandinavian mythology, was the victim of its power—

"All things in earth and air  
Bound were by magic spell  
Never to do him harm;  
Even the plants and stones,  
All save the mistletoe,  
The sacred mistletoe!

"Hoeder, the blind old god  
Whose feet are shod with silence,  
Pierced through that gentle breast  
With his sharp spear, by fraud  
Made of the mistletoe.  
The accursed mistletoe!"



Then the power of the plant to work ill was partly suspended, and only when it touched earth could it do mischief.

But the influence of the plant was not always "baleful." In an old book on medicine we are told that mistletoe is "good for the grief of the sinew, itch, sores and toothache, the biting of mad dogs and venomous beasts," which surely entitled it to the name, "all-heal," by which it was known to the Druids. In many parts of Sweden the country folk make and wear finger rings of mistletoe wood to ward off sickness, while French peasants wear amulets of the plant for the same purpose.

#### THE DOCTORS OF SHAKESPEARE.

Of the thirty-seven undisputed plays of Shakespeare, physicians appear in the *dramatis personae* of five. These are the "Merry Wives of Windsor," "King Lear," "Macbeth," "Cymbeline," and "Henry VIII." In "Macbeth" there are two, an English and a Scotch doctor, neither of whom is much of a credit to the profession of their time. One humbly admits the superiority of the king's miraculous touch to all the resources of his art for the cure of scrofula, a remedy practiced for the king's evil in England as late as in the reign of Queen Anne. The other is worse than confounded by the somnambulism of Lady Macbeth in the sleep walking scene, and admits that "this disease is beyond my practice." When appealed to for aid by Macbeth in the sonorous period beginning "Canst thou not minister to a mind diseased?" the doctor lamely and impotently replies "Therein must the patient minister to himself." This is an unusually frank acknowledgment of incompetency and shows an inexcusable lack of familiarity with the ordinary sedatives and hypnotic drugs which would have given Lady Macbeth at least temporary relief in her disturbed sleep and distressed nervous state. Such drugs were numerous enough in Shake-

spere's day, as is shown by the powerful knock-out drops of Friar Laurence in "Romeo and Juliet," which were administered to the youthful heroine with such fine effect. Henbane, theriac, opium, and probably also valerian were well known, and it seems a pity that Macbeth could not have had in consultation the physician of King Lear, who was far more resourceful, and would have been quick to prescribe for the unfortunate lady one of the many simples which he knew "whose power will close the eye of anguish."

Dr. Caius, the irascible French physician in the "Merry Wives of Windsor" and one of the aspirants for the hand of sweet Anne Page, is a good deal of a buffoon, and is made the victim of much of the horse-play of the comedy. Mistress Quickly, in urging Fenton's suit, asks Anne's mother "Nay, will you cast away your child on a fool, and a physician?" an argument which would imply that doctors were not then regarded with much favor by ambitious mothers with marriageable daughters, a social estimate which has perhaps not entirely disappeared at the present day. Dr. Cornelius, in "Cymbeline," was associated with the plotting queen in many curious experiments on animals. He has suspicion that her interests may not be solely that of a love for pure science, and declares that he will not trust "one of her malice with a drug of such damn'd nature which first, perchance, she'll prove on cats and dogs, then afterward up higher." It is interesting to note that a similar objection to animal experimentation has been raised by the latter day anti-vivisectionist. By substituting a harmless powder for the lethal draught the murderous stepmother had prepared, the doctor saves the life of fair Imogen. Dr. Butts, the royal physician in "Henry VIII," is but lightly sketched and seems to have been little more than a boot-licking parasite at the court of the polygamous

prince. None of Shakespeare's physicians rise in point of characterization to the level of Chaucer's doctor in the Prologue to the *Canterbury Tales*. While he is not described in wholly complimentary terms, he is distinctly human in his qualities, seems a real person, and is curiously modern in many of his traits.

"In al this world ne was ther non  
him lyk

To speke of phisik and of surgerye;  
He knew the cause of every maladye,  
Were it of hoot or cold, or moyste, or  
drye,

And where engendred, and of what  
humour;

He was a verrey parfight practisour.

Of his diete mesurable was he,

For it was of no superfluite

But of gret nourishing and digestible,

His studie was but litel on the Bible."

—*Editorial, New York Medical Journal.*

#### APPENDICITIS IN TRAINED NURSES.

J. N. Hall, Denver, Colo., (*Journal A. M. A.*, July 1), remarks on the frequent occurrence of appendicitis in the trained nurses at the Denver City and County Hospital where he is a member of the medical staff. Excluding mild non-operative cases, he has records of 18 patients operated on among the pupils of five Denver training schools, the total number of nurses during the time under consideration being 296. Thus 6.08 per cent. were operated on, while a considerable additional number had mild attacks of the disease. Thirteen were operated on at the beginning of an attack and five were interval operations; the average age of the patients was 23½ years, the average duration of training at the time of operation was about 14 months. Every patient recovered with a practically perfect result. While he can only theorize as to the causes of this frequency, he suggests the unaccustomed requirements in many cases of standing and walking, consti-

pation and trauma from action of the psoas muscle in working in the stooping position so often necessitated in the nurse's occupation, as worthy of consideration. The greatest single factor, however, he thinks, is the prompt recognition of the condition leading to an early and successful operation. If all cases could be managed as well he believes the mortality of appendicitis could be practically wiped out.

#### WOMEN DOCTORS OF ANTIQUITY.

The first qualified woman physician in Europe, so far as is known, was a young Athenian woman named Agnodice. In the year 300 B. C. she disguised herself as a man and began to attend the medical schools at Athens, which it was against the law for a woman to do. She afterwards practiced among the women of Athens with extraordinary success. But her secret becoming known, she was prosecuted for studying and practicing medicine illegally. The Athenian women, however, raised so furious an agitation in consequence that the case was dropped and the law repealed. Coming to later times, we find several women who obtained the degree of medicine and practiced in Europe before 1492, especially in the Moorish University of Spain. Trotula, or Rugiero, in the eleventh century, had a European reputation, and practiced as a doctor in Salerno. At the beginning of the fourteenth century Dorothea Bocchi not only received the degree of doctor, but was professor of medicine in the famous University of Bologna. Since then two other women have been professors of medical subjects in the same university—Anna Mangolini (anatomy) and Dr. Maria delle Donne (obstetric medicine), the latter being appointed in 1799. In the year 1311 an edict was issued in France forbidding surgeons and female surgeons from practicing until they had

passed a satisfactory examination before the proper authorities. These female surgeons are again referred to in an edict in 1352.—*Philadelphia Medical Journal*.

FOR CHRONIC CONSTIPATION Macmillan inserts through a protoscope a tampon—lubricated with vaseline—made of either absorbent cotton, cheese-cloth or lamb's wool. The tampon

should be of sufficient size to cause some distention of the bowel. Each tampon is provided with a cord to facilitate its withdrawal. If inserted above the rectal valves and left from two to six hours, there usually occurs a copious bowel movement within a few hours. The author, in the majority of his cases, has used the tampons on alternate days in the beginning of treatment, and as progress was noticed, he increased the interval between treatments.

## SOCIETY TRANSACTIONS.

### SOUTHERN CALIFORNIA MEDICAL SOCIETY.

#### THIRTY-SIXTH SEMI-ANNUAL MEETING AT ARROWHEAD HOT SPRINGS, MAY 2 AND 3, 1906.

The thirty-sixth regular semi-annual meeting of the Southern California Medical Society met at Arrowhead Hot Springs, near San Bernardino, on Wednesday and Thursday, May second and third.

The arrangements were in charge of Doctors Woods Hutchinson of Arrowhead Hot Springs, W. W. Roblee of Riverside, and D. Charles Strong of San Bernardino. President Hoell Tyler of Redlands and Secretary Joseph M. King of Los Angeles officiated at the meeting.

#### THE SCIENTIFIC PROGRAMME.

The scientific programme was as follows:

LUES AS A FACTOR IN GENERAL PRACTICE. *By Geo. L. Cole, M. D., of Los Angeles.*

THE PRESCRIBING OF PROPRIETARY AND SECRET REMEDIES. *By Gale G. Moseley, M. D., of Redlands.*

ALBUMINURIA IN PREGNANCY. *By F. W. Thomas, M. D., of Claremont.*

INTESTINAL OBSTRUCTION FROM PERITONEAL BANDS. *By C. Van Zwalen-burg, M. D., of Riverside.*

PRESENT DEVELOPMENT OF THE THEORIES REGARDING CARCINOMA. *By Walter B. Pomer, M. D., of Redlands.*

THE IMPORTANCE OF DRAINAGE IN ACUTE PELVIC INFLAMMATIONS. *By H. S. Gordon, M. D., of Santa Ana.*

NEOPLASMS OF THE OVARIES. *By J. M. Burlew, M. D., of Santa Ana.*

AN UNUSUAL CASE OF CEREBRAL TUMOR. *By H. G. Brainerd, M. D., of Los Angeles.*

DIPHTHERIA. *By Irdis B. Gregory, M. D., of Ontario.*

WHAT CARE AND REST CAN DO FOR INCIPIENT CATARACT, WITH REPORT OF CASES. *By Dr. Fred Baker, of San Diego.*

EARLY TREATMENT OF CONCOMITANT STRABISMUS. *By B. F. Church, M. D., of Los Angeles.*

THE INDICATIONS FOR AND A DESCRIPTION OF THE MASTOID OPERATION. *By Hill Hastings, M. D., of Los Angeles.*

NEPHRO-URETERECTOMY FOR TUBERCULOSIS. REPORT OF CASES. *By Dr. R. V. Day, M. D., of Los Angeles.*

These papers the PRACTITIONER will present in subsequent issues.

#### THE BANQUET.

The banquet was held at the Arrowhead Hot Springs Hotel on Thursday





ARROWHEAD HOT SPRINGS, SAN BERNARDINO COUNTY, CAL., WHERE THE 36TH SEMI-ANNUAL MEETING OF THE SOUTHERN CALIFORNIA MEDICAL SOCIETY WAS HELD.

evening, May 3d. After doing justice to an excellent menu, the hundred or more members present listened to the following post-prandial talks:

TOASTMASTER. *Dr. W. H. Roblee, Riverside.*

OUR IDEALS. *Dr. Henry Sherry, Pasadena.*

OUR REALIZATIONS. *Dr. Frank D. Bullard, Los Angeles.*

OUR CIVIC DUTIES. *Dr. J. C. Burke, Highlands.*

OUR RIGHTS. *Dr. George H. Kress, Los Angeles.*

OUR WRONGS. *Dr. W. B. Sawyer, Riverside.*

OUR HOPES. *Dr. W. Edward Hibbard, Pasadena.*

OUR DISCOURAGEMENTS. *Dr. A. J. Bouffleur, Chicago.*

SHAKES, QUAKES, MALARIAL AND OTHERWISE. *Dr. Woods Hutchinson, Arrowhead Hot Springs.*

These after-dinner speeches, a number of which were impromptu, were, if attention and applause count for aught, listened to with considerable pleasure by those present. The good-natured arraignment of specialists by Dr. Sawyer of Riverside is printed elsewhere in this issue of the PRACTITIONER.

#### THE MEETING IN GENERAL.

This thirty-sixth semi-annual meeting of the society was a decided success. The papers showed evidence of careful preparation, and the discussions were unusually good.

The meeting place, Arrowhead Hot Springs, was admirably adapted to the needs of the society. In the first place, the ride to the springs, the natural surroundings of the springs, and the hotel are all quite ideal, and a decided change to city men. In the second place, they were splendidly suited to the development of the social spirit, and it was the excellent fellowship so constantly manifested, as well as the good scientific programme, that made this

thirty-sixth semi-annual meeting so successful.

An idea of the natural scenery at the Arrowhead Hot Springs may be formed from the halftone which is printed in conjunction with this brief account of the meeting.

The great Arrowhead on the side of the mountain would be a wonder in itself were it not for the more wonderful springs, concerning which we take the liberty of quoting briefly from the Arrowhead Booklet:

"The waters of the springs gush out of a horizontal gash in the flank of the great Sierra Madre Range, at an elevation of nearly 2000 feet above sea level, in a sparkling, seething flood at the rate of half a million gallons a day. Their purity is sufficiently attested by their temperature—196 degrees, as high as would be required for sterilization in a laboratory, and at which no known pathogenic germ could live. Furthermore, this indicates their escape from enormous depths, beyond possibility of contamination, where either active volcanic changes are taking place or the layers of the earth's crust are crushing and grinding against each other at enormous depths, beyond possibility of heat. The whole mountain range is their soda-water fountain or champagne cellar. If there be any healing power which has to be wrung out of the bowels of mother earth, radio-activity or what not, they ought to have it. Yet they bubble up in such abundance that not merely can baths be supplied for a thousand people daily, but the hotel and buildings are heated with the spring water, running through pipes and registers, one of the few self-heating establishments in the world.

"They are the hottest curative springs in the world."

The banquet was not concluded until early Friday morning. Then all adjourned to their rooms, in order to get

an early start and be ready for the tallyhos and automobiles that would make connections with the morning trains. It was a gay party that left Arrowhead Friday morning, and the excitement of the occasion was heightened by the final dash for the train, which all, however, were able to make, even though some were minus tickets.

### THE SEMI-ANNUAL MEETING OF THE SOUTHERN CALIFORNIA ANTI-TUBER- CULOSIS LEAGUE.

The semi-annual meeting of the Southern California Anti-Tuberculosis League was held on the evening of May first, at the First Congregational Church in San Bernardino. The following account of the meeting is taken from the *San Bernardino Daily Sun*.

"That tuberculosis is a contagious disease and that its spread can therefore be prevented by proper measures was the subject presented before the public at an open meeting of the Southern California Anti-Tuberculosis League, held last night in the First Congregational church.

"So thoroughly in earnest were all the speakers that they presented their subjects in a way that held the attention of the representative audience, which filled the church, and many laymen were led to sign the membership enrollment, thereby enlisting their efforts with that of the league to secure legislation that will safeguard the public from the terrible scourge and at the same time offer intelligent treatment to the afflicted poor.

"Dr. H. G. Brainard, of Los Angeles, occupied the chair as president of the league, and Dr. C. C. Browning, of the Pottenger Sanatorium, at Monrovia, served as secretary. During the evening vocal music was furnished by Mrs. H. M. Barton and Mrs. H. F. Andrews.

"Dr. Brainard opened the meeting

with a brief explanation of the object of the meeting, touching on the work being done by the league, and explained that since the nature of tuberculosis had become understood and proper treatment given the poor, the death rate from this disease in New York alone had been reduced 25 per cent during the past 15 years.

"Dr. C. C. Browning followed with a more complete presentation of the object of the league, and explained at length the various obstacles which had been successfully encountered. His remarks were followed by a masterly presentation by Dr. Woods Hutchinson, of Redlands, on 'The Predisposing Cause of Tuberculosis.'

"Throughout his address there ran a tenor of hope for the afflicted ones, and a bugle call to the well and healthy to stand forth and check the spread of the terrible white plague. Certainly all were much impressed by the doctor's appeal and warning.

"Dr. George H. Kress, of Los Angeles, followed with a further warning, pointing out in a forceful way the duties of every citizen in the prevention of the dread disease, and following Dr. Kress, a timely address was made by Rev. E. K. Holden, giving his observations as a layman.

"The league appointed Mr. F. Coulter, of Los Angeles, and Dr. F. M. Pottenger, of Monrovia, as delegates to the national convention of the league which was to meet May 16, 17 and 18 in Washington, D. C."

A SNAKE-POISON REMEDY used by the "cowboys" of the Indian Territory, is the pure powdered indigo, which, when placed on the wound, seems to draw the poison entirely out. The "cowboys" carry little bags of indigo to be ready in case of emergency, either for themselves or any of their animals—horses, dogs, or cattle.



## BOOK REVIEWS.

GENITO-URINARY SURGERY AND VENEREAL DISEASES. By J. William White, M.D., John Eben Barton, Professor of Surgery, University of Pennsylvania, and Edward Martin, M.D., Professor of Clinical Surgery, University of Pennsylvania. Illustrated with three hundred engravings, and fourteen colored plates. Sixth edition. Philadelphia and London: J. B. Lippincott Company.

The reviewer has followed this book very carefully since its first edition in 1897, and all its editions are before us as we write. The book has always presented the pathology, symptomatology, diagnosis and treatment of syphilis and the genito-urinary diseases in a clear, concise manner, with, however, sufficient detail to make them readily understood. In a sense the work is a personal one, particularly in its chapters on treatment, where the authors have given those methods which have proven of value in their hands, although other methods have not been excluded from the text.

Throughout all these years the book has been of practical use to many physicians on account of the space devoted to symptomatology, diagnosis and treatment, three subjects that, after all said and done, are of the most interest to the every day, hard-working practitioner.

The pathology is briefly considered, but the moot questions have not been introduced to confuse the reader. Since all good work in genito-urinary diseases depends absolutely upon antisepsis and operative and manipulative technique, these matters have been carefully amplified. No less important are the modern methods of examination of the genito-urinary system, and without a full knowledge of these methods exact diagnosis and correct scientific therapeutics are impossible. The practitioner will find these chapters all that they should be, and particularly will he find the comprehensive study of the changes in the urine produced by disease of

more value than is usual in surgical text-books.

The knowledge of the wants of practitioners and students, gained by the long teaching careers of both the authors, is everywhere visible throughout the book.

From time to time as new editions were demanded the authors have added such practical modern procedures as their experience and judgment have shown to be of distinct value, and this last edition, which is now under consideration, has been revised in accordance with the latest teaching and practice.

The current literature has been carefully culled, and a wise selection from it of such facts and procedures as have proven worthy are to be noticed throughout this edition.

All the improvements of technique that are commendable find a place in the text. Many new illustrations have been added, and all the old ones that are valuable have been retained.

The section on prostatic hypertrophy has been practically rewritten, and as it stands is fully *au courant*.

The index is to be commended; it is full and complete, and replete with cross-references, which are always a test of the value of an index.

The reference word is printed in bold type, and black face type indicates the more important subdivisions of the reference word. This index adds very materially to the value of a very excellent book.

W. A. E.

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CULBRETH'S MATERIA MEDICA. A Manual of Materia Medica and Pharmacology for Students and Practitioners of Medicine and Pharmacy. Comprising all Organic and Inorganic Drugs which are and have been official in the United States Pharmacopoeia, together with important Allied Species and Useful Synthetics. By David M. R. Culbreth, Ph. G., M. D., Professor of Botany, Materia Medica and Pharmacology in the University of Maryland, Departments of

Medicine, Pharmacy and Dentistry. Fourth edition. Revised to accord with the new U. S. Pharmacopoeia, Eighth Decennial Revision. Octavo, 976 pages, 487 illustrations. Cloth, \$4.75 net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906.

This work, which is now in its fourth edition, shows great care in its preparation. It is brought sharply up to date. Cognizance has been taken of the recent advances and newer knowledge, and it accords with the new edition of the United States Pharmacopoeia, in which both the strength and consequently the dosage of important medicines have been much changed. The practicability and utility of the book is assured from the author's knowledge of the every-day problems of the pharmacist, because he, himself, spent twenty years of his life in the retail drug business.

The book is very evidently the production of one who is familiar with the subject-matter, and who is accustomed to impart his knowledge to others. The volume opens with a general discussion of *Materia Medica* and the physiological action of drugs, taking up the forms in which medicine may be used, the avenues through which they enter the human system, the means by which they are transmitted through and eliminated from the system, and conditions which modify their action and dosage. Then follows a clear statement of classifications, alphabetical, chemical, morphological, anatomical, botanical, therapeutical, etc. The greater part of the volume is taken up with a clear, comprehensive covering of organic drugs from the vegetable kingdom, inorganic drugs from the mineral kingdom; organic carbon compounds and synthetics, including both official and non-official. A section is devoted to the study of the microscope, and its practical uses in *Materia Medica*, and the volume closes with an appendix of great usefulness, covering poisons and antidotes, prescription writing tables of

weights, measures, doses, abbreviations, pronunciations, etc. An unusually full index renders instant reference to any subject easy, and completes a work which stands without an equal in its field of practical value and authoritative statements.

W. A. E.

OSBORNE'S INTRODUCTION TO MATERIA MEDICA AND PHARMACOLOGY. An introduction to the study of *Materia Medica* and Pharmacology, including the Elements of Medical Pharmacy, Prescription Writing, Medical Latin, Toxicology and Methods of Local Treatment. For the use of Students of Medicine and Pharmacy. By Oliver T. Osborne, A.M., M.D., Professor of *Materia Medica*, Therapeutics and Clinical Medicine in Yale University, ex-President of the American Therapeutic Association, etc. In one 12mo volume of 167 pages. Cloth, \$1.00 net. Lea Brothers Co., Publishers, Philadelphia and New York, 1906.

BERG'S SURGICAL DIAGNOSIS. A Manual of Surgical Diagnosis. For Students and Practitioners. By Albert A. Berg, M.D., Adjunct Attending Surgeon to Mt. Sinai Hospital, New York. In one 12mo volume of 543 pages, with 215 engravings and 21 full page plates. Cloth, \$3.25 net. Lea Brothers & Co., Publishers, Philadelphia and New York.

The number of books that have been recently issued which have to do solely with the question of diagnosis is an encouraging sign of the times. Particularly is this so in surgery and its hand-maiden—gynecology. We are passing through, and fortunately have almost passed, a period of operative craze, more so perhaps, in gynecology than in any other branch of surgery. Diagnoses have been disregarded, and our patients have been placed on the table with the idea and hope that opening the belly would reveal all of the hidden secrets that we in our hurry would not give the necessary time to elucidate before submitting our patients to the dangers and uncertainties of surgical manipulation.

There must be a demand for these books, else why are they written? Publishers are not eleemosynary corpo-

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which goes to form the treatment of the secondary anæmias is iron; the other constituents of the arch comprise such remedies as aid digestion and improve nutrition.

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rations. This demand then shows an awakening in the profession to the fundamental importance of accurate diagnosis. Without it our science and our art becomes but haphazard guessing. Aseptic methods and improvements in operative technique have so widened the field of surgery and brought many of the internal organs within the range of successful surgical treatment that new methods of diagnosis are imperative, to say nothing of improvements in the older and well-tried means of arriving at pre-operative conclusions.

The light that has been thrown upon the early stages of disease processes by laparotomy and exploratory incision, the close analysis and classification of the clinical manifestations of individual diseases that have been made by

those who have the opportunity for observing large numbers of patients, and the aid that the pathological, bacteriological and chemical laboratories afford for the interpretation of the phenomena of disease has made it possible to recognize most of the maladies that are surgical in character in their incipency. In this book a general plan has been adopted for developing the diagnostic factors. First is given a concise clinical picture of each disease, including its cause, onset and course, and in certain cases the accompanying pathological changes. In each instance are indicated the points of difference between the disease under consideration and diseases of other organs which might be mistaken for it.

It is of course impossible to write a complete book on surgical diagnosis



even at this day, as there still remain some diseases which we cannot diagnose early; cancer of the internal organs being a notable example of this class.

Continued exploratory incisions and further clinical observations will no doubt give us the necessary data, but just now we do not possess it. The chapters on Diseases of the Gall Bladder and Diseases of the Pancreas, while they are small and much condensed, are very valuable, and are as clear an exposition of these new and live subjects as I know of in the recent literature. A careful reading of the sixty-five pages of the chapters dealing with Diseases of the Genito-Urinary organs, leaves one with a feeling of satisfaction and commendation, and we recognize that Dr. Berg is exceptionally well qualified to furnish a most practical and useful book, by reason of the fact that the surgical service of one of the large-

est and most perfectly appointed hospitals is, and has been for years directly under his observation. The wide range of his experience and the broadness and accuracy of his knowledge are clearly reflected in the completeness and precision of this manual. It is a work admirably adapted to the needs of the student, and equally valuable to the general practitioner or surgeon, as a concise and trustworthy guide in the diagnosis of all surgical affections.

The few words devoted to the study of the chemical composition of the gastric juice might with propriety be somewhat amplified; they are too much condensed to be of value and show a little haste in preparation. The well known Gunzberg's solution is incorrectly spelled. On the whole, however, the author has covered the subject of modern surgical diagnosis in a most acceptable manner.

W. A. E.

## THERAPEUTICAL HINTS.

*The Chicago Clinic and Pure Water Journal* in the course of an editorial says: The sentiment which underlies the present efforts of certain worthy medical men, to protect the profession from imposition and to make our therapy clean, reliable and trustworthy, is entirely laudable and commendable. The extent to which some of these gentlemen are permitting their enthusiasm to carry them is lamentable. The judgment passed upon many of the pharmaceutical preparations which have stood the test of time for years in the practices of thousands of successful medical men, has seemed hasty and ill-advised. To one who is prejudiced in neither direction, who endeavors to look at the matter with perfect fairness, it is very questionable if it is right that a small faction of the American Medical Association should use the organ owned by all of the members to condemn or de-

tract from the reputation of long established pharmaceutical preparations, many of which are used regularly by a large part of the membership of the Association.

Pond's Extract of *Hamamelis Virginiana* (as the plant is botanically described by Hare and Shoemaker, or *Virginica*, according to Coston) has been relieving pain and performing other beneficent functions in the conditions indicated by Shoemaker for the past sixty years. While it has been imitated and substituted in every conceivable form during this extended period, it stands out today all the more efficient and esteemed by such comparison, and, in addition to its superlative medicinal properties and action, is a positive guarantee to physician and patient alike against any and all of the poison perils of the common commercial witchhazels

so vividly portrayed by Buller, Wood, Darlington, Lloyd, Hare, Gamble, London Lancet, Journal of the American Medical Association, Medical News, Medical Record, Therapeutic Gazette, Boston Medical and Surgical Journal, Druggists' Circular, Bulletin of Pharmacy, Western Druggist, and numerous other medical writers and professional publications of equal standing and authority.

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**SANMETTO IN IRRITABLE CONDITIONS OF THE URINARY TRACT. ALSO IN GONORRHOEA AND GLEET.** Some months ago I gave Sanmetto a trial, since which time I have been a very warm admirer of it, as I find it is exactly what it is claimed to be. It acts finely in irritable conditions of the urinary tract, and also in gonorrhoea and gleet. I do honestly wish physicians not acquainted with Sanmetto would give it a fair trial.—H. L. Helms, M.D., Memphis, Tenn.

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Dr. P. M. Hawkins of Craig, Texas, writes that he uses Alkaloidal Granules extensively, and that they are quickly soluble in water, and make a perfect solution. Dr. Craig says that he finds them also very satisfactory when used hypodermically, and that he finds them of uniform strength.

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Dr. W. T. Marrs of Jewett, Ill., writes in the highest terms of Antikamnia and codeine tablets as the ideal pain reliever, especially in chronic conditions such as headache, neuralgia, cancer and chronic rheumatism.

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#### INVALUABLE RECOGNITION OF A MERITORIOUS ARTICLE.

Dr. B. K. Rachford, Professor of Diseases of Children, Medical College of Ohio, University of Cincinnati; Pediatrician to the Cincinnati Good Samaritan and Jewish Hospitals, Member of American Pediatric Society, Association of American Physicians, etc., in

his book, "Neurotic Disorders of Childhood," published, 1906, by E. B. Treat & Co., New York City, in Chapter XIX, "A clinical study of cases illustrating the kinship of recurrent vomiting, recurrent coryza, toxic epilepsy and migraine," advises for the medical treatment: "Phosphate of soda or Kutnow's Carlsbad Powder before breakfast each morning in a dose sufficient to move the bowels, etc."

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Dr. John Johnson Kyle, Clinical Professor of Otology, Rhinology and Laryngology in the Medical College of Indiana, Department of Medicine of Purdue University; Otologist, Rhinologist and Laryngologist to the City Hospital, St. Vincent's Hospital and City Dispensary, Indianapolis; Fellow of the American Academy of Ophthalmology and Oto-Laryngology, and Member of the American Larynological, Rhinological and Otological Society, etc, recommends in his "Manual of Diseases of the Ear, Nose and Throat," published, 1906, by P. Blakinston's Son & Co., Philadelphia, in Chapter XII, Diseases of the Middle Ear, for the treatment of acute myringitis: "Rest in bed, free purgation with calomel, followed by magnesium sulphate, Kutnow's Powder or Hunyadi water is indicated."

Many other medical authors have frequently in their works recommended Kutnow's Powder in a similar manner, an undeniable proof of the therapeutic merits of the same.

In the treatment of cannon-cracker wounds and other injuries caused by the explosion of fireworks, which may be expected on our approaching national holiday, anti-tetanic serum should be injected in a single dose of 10 C.C. immediately after the receipt of the injury, to be repeated ten days later. The wound is to be thoroughly cleansed and packed with gauze, well charged with anti-tetanic dusting powder.

Dr. Samuel Johnson, talking of the eminent writers of Queen Anne's reign, observed: "I think Dr. Arbuthnot the first man among them. He was the most universal genius, being an excellent physician, a man of deep learning, and a man of much humor."

**TWENTY FIVE PRACT ROBINSON CURRAN POPE**, in *Advanced Therapeutics*, says: Though the value of ingestion by the patient of large quantities of water during many of the febrile diseases is a recognized fact in therapeutics it is a point insisted upon much less frequently than it deserves. E. F. Cushing and E. W. Clarke detail the clinical results in one hundred cases of typhoid fever in which the patients took as much as a gallon or a gallon and a half of water daily, resulting in a polyuria corresponding closely to the amount ingested. As compared with other cases not so treated, these patients were invariably more comfortable, and the mortality seemed to be still further diminished when this method of hydrotherapy was employed as an accessory to the cold bath treatment. It was found that the eliminating capacity of the kidneys is not injured in typhoid fever nor by prolonged polyuria. These studies emphasize the value of large quantities of water in the treatment of typhoid fever patients.

**BALDNESS.**—Dr. Parker, of Detroit, has been making investigations to ascertain the causes leading to baldness, upon the theory that air deposited in the alveoli of the lungs which is not utilized in respiratory process yields, in the presence of moisture and warmth, a poison which he names trichotoxine or hair poison. To bring into exercise the alveoli of all parts of the lungs for breathing purposes, and to avoid conditions that facilitate the poison of baldness, the upper ribs should rise and fall

with each act of respiration. It is contended that in persons not bald this always occurs, and in persons affected with baldness it does not occur; that if his manner of breathing is practiced, baldness will not develop, and if this habit is re-established after being lost, baldness that may have resulted from its absence will be repaired.

**POLYURIA**, a favorable symptom in typhoid fever. Simon in *British Medical Journal* notes that polyuria occurs not only in every case that does well, but also in many cases of great severity in which no general improvement or amelioration of symptoms can be observed. But even in severe cases, if polyuria occurs, the patients recover. In no case with polyuria has perforation been observed by him nor any hemorrhage of any moment. Further, relapse is of the most extreme rarity, once polyuria has been established.

**THE ACTION OF CYPRESS OIL** in the treatment of whooping cough is being noted in foreign journals. In the use of the agent Soltmann and some others have made some experiments. The mode of administering recommended by him is the application of an alcoholic solution of cypress oil (one to five) to the bed sheet and pillow of the children. Ten to fifteen grams are used three to four times daily. Should the coughing spells disturb the sleep, similar applications are made once or twice during the night.

**JOHN WHERRELL** says: Based upon digestion, patients may be divided into two classes: (a) Those who can digest all they eat, but cannot assimilate all they digest; (b) those who can assimilate all they digest, but cannot digest all they eat. The former leads to constitutional disturbances, such as diabetes, the latter to local stomach troubles.



**FOR QUICKLY CURING ACUTE GONORRHOEA** injections into the urethra of one drachm and a half of solution of silver nitrate, at first four per cent strength, later two per cent and one per cent strength, is recommended. In most cases a single injection is sufficient. It produces a little pain, and soon the gonococci disappear from the secretion. If they are still found the injection is repeated. When not cured by three injections, the treatment is not continued. The method depends for its effect upon the fact that early in the disease the gonococci lie entirely upon the outer layer of epithelial cells, multiplying on them, destroying their vitality, and causing them to exfoliate. In chronic gonorrhoea the same methods might be employed with the addition of Sanmetto internally in drachm doses, four times a day.

**GASTRIC PAIN.**—For many years Professor Whitford has taught his classes to prescribe the bicarbonate of soda freely where there is persistent pain in the stomach, often depending upon gastric ulcer. Sir Lauder Brunton has recently advised that a teaspoonful of the bicarbonate of soda in a little lime water, to which the essence of peppermint has been added, gives a more speedy relief from pain from gastric ulcer than morphine. In many cases, by the neutralization of acid fluids present, it will produce relief where morphine will not.—*Chicago Medical Times.*

**IT IS SAID THAT** berberis aquifolium, in combination with echinacea and Fowler's solution of arsenic, so as to make the average dose consist of five drops berberis, five drops echinacea and one-tenth drop Fowler's solution, is not only an excellent tonic and blood medicine, but a very efficient remedy for removing pimples and blotches from the skin, especially those on the face and for making the complexion soft and

clear. This mixture has been prescribed many times as a *beautifier* with considerable success.

**DR. ALFRED L. LIVINGSTONE** HOLDS that while ergot acts upon all blood vessels to contract them, it acts most upon those which most require its action; that it to say, it exerts a *specific* action upon *over-distended* vessels, thus producing equilibrium of the circulation. This explains its action in headache and insomnia, for insomnia is due to cerebral hyperemia, to which cause also are due headaches; and even in an anemic headache there would probably be hyperemia elsewhere, and so the use of ergot would still be indicated.

**ALL WATCHES COMPASSES.**—Point the hour hand to the sun and the south is exactly half way between the hour and the figure XII on the watch. For instance, suppose it is four o'clock; point the hand indicating four to the sun, and II on the watch is exactly south. Suppose it is eight o'clock; point the hand indicating eight to the sun, and the figure X on the watch is due south.

**MEDICINE IS BEST GIVEN** just after meals when the drug is known to be irritating in action upon mucous membranes. If rapidity of action is desired, it is advisable to direct the drug to be taken between meals. All kidney remedies do much better when administered from a half hour to an hour before meals. Acids are best given half an hour after meals, in preference to being administered directly after eating.

**IF YOU CARRY SCREW-TOP BOTTLES** in your case and use liquids, especially iodine, put corn-stalk pith in your screw cap, instead of shaved cork, and it will stop the leak.

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## SCIENCE, RELIGION AND THE PHYSICIAN.\*

BY THE RT. REV. THOMAS J. CONATY, BISHOP OF MONTEREY AND LOS ANGELES, CAL.

I esteem it an honor to have been invited to deliver the address to this year's graduates of the College of Medicine of the University of Southern California.

The world recognizes the high character of vocation of the medical profession. Through the ages, noble and disinterested men and women as physicians, have lived and devoted their lives to care for and preserve the lives of others, and they rank among the benefactors of humankind.

The object of the medical profession is human life and with man the physician deals directly. The study of medicine leads one to the proper understanding of the human system, its strength and its weakness, in order that through knowledge, suffering may be minimized, life lengthened and something of earthly happiness obtained. History records the honor in which the physician has always been held among men. "Honor the physician," says the Holy Scripture, "for the need thou hast of him, for the Most High hath created him." Indeed, we are not surprised that simple races

looking upon his benefactions have regarded him as a preternatural being and were prepared to worship him as something divine.

In the Providence of God, life and death are in his hands. He cannot produce life, but he can at times prolong it; he cannot prevent death, but he can at times delay it. God decreed life and death and He has sent ministers for both. Life comes from God and belongs to him who receives it and until his utter personal unworthiness is proved by his acts, he has the right to it which no one on earth should touch.

The Greeks used to say, "To become an able man in any profession three things were necessary,—nature, study, practice," in other words, vocation, knowledge, application. To minister to human life, to protect and defend the human system against disease, to relieve suffering, to help nature fulfill its purposes, is indeed a most honorable vocation. Let no man presume to enter upon it unless he hear within his soul the call of humanity to it, and feel the

\*Address delivered at the commencement exercises of the College of Medicine of the University of Southern California, at Los Angeles, June, 14, 1906.

appetite for the lines of duty demanded by it. Fidelity to vocation demands knowledge in order that reasonable service may be given. Knowledge requires application, constant application perfects knowledge and prepares one for duty. Ambition is laudable when it inspires one to the best possible work, urging one to reach the top in order the better to do good.

The idea of ameliorating the conditions of human life, in fact, of making life more and more worth living, should take possession of the professional physician as a passion, and privation and labor should be welcomed as test-stones of devotedness to the ideals of his vocation. Few men are gifted with great genius, but all men may have determination of soul and strength of heart by which the talents given by God may be utilized for the benefit of mankind.

We love to look upon the physician as a benefactor, as one going about doing good to poor suffering humanity. In that view of his life, he must remember that the sources of his strength and the force of his influence lie primarily in his character. As Wordsworth happily describes it:

"Who comprehends his trust and to the same  
Keeps faithful with a singleness of aim;  
And therefore does not stoop, nor lie in wait  
For wealth, or honor, or for worldly state;  
Whom they must follow, on whose head must fall  
Like showers of manna, if they come at all."

The aim and purpose of the good physician should be fashioned on the aim and purpose of the good Saviour whose one thought was the good He could do others. That the skillful physician should be also the man of good character should be the aim of every true physician. Our knowledge is of little use unless it improve our character and develop in us faculties by

which we not only become and remain good ourselves but render our lives more efficient in promoting the well-being of others. Intelligence and moral virtue are essential elements in the good character of a physician. They are greater than money, they are powerful and noble. Sterling character is built upon goodness of life. To be a man of culture, a man of books, familiar not merely with the technical books of one's profession, but with the books that give an insight into human character and lead to the understanding of human nature, these should be promptings in every physician's life.

Success in life is not measured altogether by victories. Failures, properly understood and appreciated, are frequently sources of life's ultimate success. No man can go through life without at times failing in the things he starts out to do and sometimes failing most egregiously. The man with the mark of success upon him is the one who has not allowed failure to discourage him, but who has risen from each failure with the determination of studying the cause in order to avoid future failure. The history of successful men in every walk of life has many a chapter of failures. It is but another experience of the crown through the cross. Difficulties are oftentimes our best masters, they serve to discipline the character, they test the values in us, they make for the worth of life, they give the sterling ring to the character. The mere sighing after the ability to do the great things done by others never goes beyond the difficulty that arises at the very suggestion in the sigh. Success is in the wish when with it there is energy and determination. Every temptation to discouragement conceals a victory which may be won by fidelity to the aim and purpose which lie before us. The conquest of difficulty brings the pure gold of success.

Hard study, patient application, unceasing repetition, the use of opportuni-



ties, have been the great masters in all the things that have brought laurels to the efforts of men. The masterpiece of an artist has oftentimes cost him years of his life, but the feeling that it is a masterpiece and will live forever is worth the privations and sacrifices of an entire lifetime. The sculptor never forgets that the statue lies hidden in the block of marble, awaiting the constant stroke of his hammer and his untiring energy and skill, that it may live as his masterpiece. The stones of the Parthenon were not cut out with one blow of the chisel.

All men are called to high character, to high-mindedness, to cleanliness of soul, to uprightness of life, to union of soul with the great God. The call to high character is stronger to no class of men than to the physician, whose vocation binds him to the closest possible touch with life itself. His to share the deepest confidences of our nature, to be in sympathy with human suffering, to alleviate pain, to help poor human nature sustain the shocks which come upon it. No man more than the physician should make the world feel that there is in him nothing of the mercenary or the heartless, but that he always is the benefactor of his kind, caring tenderly and lovingly for those confided to his care.

"Before thy eyes, duty, a constant flame,  
Shines always steadfast in the unchanging light,  
Through dark days and through bright."

Here rises at once to our mind the idea of conscience which should guide his whole life. The strongest word in any language is conscience; the sternest, most universal obligation in life is obedience to it. The very soul of strength to character is an intelligent, well instructed conscience. The universal law in all nature is the law of service. The little things of life, kindly acts, the moments of self-sacrifice, duty well performed, make for nobility of character. The poorest among us may

become the richest through fidelity to the trivial things of daily life. Written across the face of life is this law of service, service of man to God. With character befitting the vocation of the physician comes knowledge of his duty. Versed in the law of life, he should know and revere the commandments of life, having in his soul a devoutness and a reverence for the conscientious belief of those to whom he ministers. Human life is his study, the understanding of it brings the knowledges he needs. Human life is the important study for the physician, its questions are the important questions. Sad the condition of mind of the physician who has lost faith in God, who looks upon humanity as something merely material, and on existence as something limited by time. We are happy in believing that we are something better and higher than the most intelligent of animals, and reason itself leads us to locate that something in the immaterial and spiritual substance called soul which vivifies and preserves existence.

Thank God, men yet believe in a soul which is beyond the power of human investigation by mere human instruments. Science alone cannot answer the fundamental questions of life satisfactorily, because they are beyond the sphere of science. Science is limited by the natural, it cannot deal with the immaterial, the spiritual. The laboratory can only reach to the flesh and blood, the bones and sinews, but the thing that makes us the men we are, that differentiates us from all other things in creation, is not found by the material investigation; there is a line reached by the laboratory, and beyond that line lies mystery. This is even in plants and flowers and beasts, much more so in the highest of all created things, man. You know what you see and feel, you judge by results, you study effects, but life itself, whence it comes and why and wherefore, are questions science can-

not answer. Pygmalion may chisel a Galatea which almost speaks, but it does not speak and he cannot give speech to it; the author of life alone can do that.

Dr. Osler, in his book on "Science and Immortality," says: "Modern psychological science dispenses altogether with the soul." Notwithstanding this dogmatic utterance of Dr. Osler, our moral and intellectual nature will still continue to assert that there is something more to our personality than the merely moral and material.

A writer in the *Atlantic Monthly* for June, speaking of this statement says: "If by soul he means the inner personality which includes our moral and intellectual nature, all talk of dispensing with it, is as absurd as for a mariner to talk of dispensing with his compass."

It is well for us never to forget Hosea Bigelow's philosophical advice, "not to prophesy unless ye know," and this is still good advice to men whose field of vision is limited to natural phenomena, and who have no glass strong enough to penetrate the thing called "life."

The religion and intellectualism of the centuries asserting belief in soul must be expected to refuse to be cast upon the ash heap of foolish vagaries by the unproved dogmatism of a scientist. It has heard many times what is called the last word of science, only to find afterwards that it was a theory and not a fact and was not justified by events. It is well to remember that the word of a scientist is not always the word of science. Pasteur, whose name shines with honor on the roll of great physicians, has definitely shown that life comes from life, thus exploding the theory of spontaneous generation which until recent times was considered essential to the correct knowledge of the physician.

The student of human life needs to be warned against an unfortunate tendency in the modern study of medicine to do away with the religious element, to build upon the materialistic ideas, some-

times atheistic, largely anti-religious, falsely alleging the antagonism of religion and science. It is unfortunate to science that anything should come to loosen the ties that bind us to the God of Revelation. Religion and science are both expressions of the truth of God, one by the word of Revelation, and the other by the word of nature. It is consoling to notice that the pendulum is swinging back toward a better appreciation of the relation between religion and science in the proper understanding of human life and its duties. The art of healing must live from close contact with the Great Author of all life.

Every age has its fads and faddists and science does not escape from their influence. No one can question the facts of science, but we are often called to question the accuracy of so-called facts which are frequently the fancies of scientists. Science cannot go beyond the natural, and its attempt to displace the supernatural, to do away with the God of nature, is an evident effort at things beyond the knowledge of its trade. They would destroy the God of the Christians only to manufacture one which has the hands and feet of a man, but not as good a man as the one whom they investigated in their fields of scientific research.

Bacon expresses the hope that the nobler sort of physicians will become coadjutors and instruments of divine omnipotence and clemency in prolonging and renewing the life of man. Therein is found a noble ideal. There is no one thing in human science for which we have reason for greater gratitude than the development of the knowledge of disease, its remedies and its causes. The world in its early history, and indeed until modern times, shows but feeble efforts in the great study of the physical condition of man. True, illustrious names from Hippocrates and Galen to Harvey, appear in the early as well as in the middle ages, but the science of investigation which always

existed in some degree, received its impetus and success from the development of the modern schools in which opportunities were given for scientific research which leads to usefulness toward human life. The results of the laboratory have made it possible to control disease and frequently to prevent it. The success of modern surgery is largely due to the agencies which have sprung to its assistance from the researches of the laboratory.

Religious faith vested with divine authority to give to mankind the message of God is alone capable of giving the true answer to the questions of life which lie beyond the microscope and the knife. The nearer the physician comes to the fullness of faith in God, the more fully he believes in a Divine Revelation and its completeness in Christ, and the better, according to my belief, will he understand the origin and purposes of human life, the sanctity of a life, the inviolability of human relations, in a word, the absolute and inalienable right of the individual life to be allowed to live. God is to him the prime source of the knowledge of life in his great study of human nature battling for existence. The physician, a man of faith, a man of virtue, of absolute probity, with high ideals, understanding life and death, is, indeed, the man in whose hands we love to sacredly repose that which is dearest to us, our own life.

Such a man will never trade upon the frailties and follies of human nature. He will have a reverence for the golden standard of justice, justice to the life committed to his care, even to that of the unborn life. Experiments will not be made by him in the uncertainty of the consequences to human life as he remembers that it is not his to take life but his to preserve it. He will never allow himself to yield to the temptation of bartering his profession for ignoble gain. There are fakirs in every profession, men who wear the robes of their profession only to trail them in the mire

of unprofessional and unworthy acts, who live for sordid aims, who prefer success to right living and are governed by greed and gain, and feed on the miseries and crimes of their fellows. The true physician, like the true minister of the Gospel, values his vocation as a noble Christian one, which calls him to work for the highest and sweetest things in human life. The robe of the physician is a royal one and entitles him to rank in the kingly palaces of great and good men. Moral character to him is the most important and valuable of all his assets, for by this he reaches the confidence of human hearts and in this confidence lies his success.

The memories of childhood of the older ones among us bring to us the picture of the old family doctor, whose years of service from births to deaths had entitled him to membership in the household. The old white horse and the two-wheeled gig, the box of medicine, the candy for the children, all rise up before us as we bless his dear old heart which had so much of affection for us all. His office hours were all hours, he was never supposed to sleep, never to be tired, never too busy for a call. He made his own pills and powders, mixed his own medicine and saved us the expense of the town pump water at the apothecary shop. He usually located the storm center of the disease in bilious conditions, and gave drastic doses according to the size of the patient, but he was usually correct in locating the cause of the trouble and always gave medicine enough for his money. He had more common sense than technical skill, but common sense is a valuable asset of every physician. He had little knowledge of laboratory or microscopic analysis, there were no learned societies which he attended, and there were no degrees to his name, he had no acquaintance with modern terror names, he knew nothing of fads and fashionable ailments; he was a plain, blunt, matter-



of-fact, every-day doctor, no specialist, but a general all-round practitioner. He had no germ theories, and knew little of microbes or bugs, but the tongue and the pulse were his mediums of diagnosis. He had no trained nurse to help him, but used the good neighbor woman who always came in, and he was glad to most formally instruct her concerning the regularity of the doses. He was two-thirds good nature, and one-third gruff. He was the man for the times, never a sunshine or daytime doctor, but always ready for every call, no matter what the weather or the distance. Everybody knew him, and knew him as a friend. He was good in his character, generous in his charity, easy in his collections, kind to his patients, devoted to his duty. The remembrance of the old family doctor of half a century ago is a pleasant one, and his name is in benediction as a simple, honest lover of his kind, faithful to all the demands of his patients. His day has passed, but let us not forget his merits, and his success. He was a slave to duty as he knew it.

Helpfulness is the call humanity makes on the physician. To be of help to human beings is of higher aim than that of wealth, or honor, or fame. The masters of finance may build a mighty system by which the commerce of the world is controlled, the captains of industry may turn the wheels by which the development of a country may be assured, but no Napoleon of finance or captain of industry ever did for the world as much lasting good as that done by the one who, serving his fellow men, relieves suffering, restores the shattered frame to health and strength, and brings sunshine into a life full of sorrow because of affliction.

The physician should have a belief in himself, be resolute in purpose, full of confidence which comes from accurate knowledge. The physician is called to be a man in every sense of the word,

true to himself, full of religious and moral sense, with well-defined principles of moral action. He should be unselfish, for selfishness is self-centered, dries up the sources and roots of charity; it narrows the heart and warps all gentle feeling, strikes at true brotherly love, chills all humaneness. The man whose life is in the field of mercy, whose vocation is to the healing art, ought to be full of unselfishness. He should never tire in the study of his science. Scholarship is demanded for successful work. A case may be tedious, it may mean sacrifice of time and energy, but frequently it is the best book for his study; in it the thoughtful physician finds experience and development of knowledge. Chapters of valuable information are written in the hourly march of a patient's symptoms. The wave motions of disease are sources of knowledge. Every case demands your best service. As a general rule, it is the man who studies in the hard school of practical experience who succeeds. Some men may have the learning of books, yet their advance is slower than that of others who with less knowledge are observant men, who learn by their cases well studied to finally master the profession.

Divine Providence honors exertion and crowns effort with success. Difficulties overcome are the stepping-stones to greatness. The ability to resist the influence of jealousy and unkind criticism is a source of success. The history of every great man who has impressed himself by his ability upon the moral world is a history of perseverance in the face of every difficulty. Never to know what it is to relax in energy, to lose hope, to turn one's eyes from the mountain top where lies the crown of successful labor, this is indeed the secret of greatness.

The knowledge that in one's life work there is nothing trivial makes a man take advantage of the slightest oppor-

tunity to perfect himself for the work that lies before him. The research in all his scholarship is toward accuracy. There is no accurate knowledge of facts, no matter how insignificant, without value. A small detail may determine a life. Foundations deep and well laid are the source of a building's strength. To work well at the foundations is to insure the safety of the building. So it is in a profession, in business, in every sphere of human endeavor. When there is question of human life and responsibility and care for it, there is no foundation stronger than that which is built upon one's own conscientious appreciation of duty.

Members of the Graduating Class: It has been my privilege to make the address of your graduation day. It is also my privilege to congratulate you on the successful ending of your years of preparatory study. You have been trained under competent, devoted masters in the technical lines of your profession. The methods to be used, the tools to be handled, have been made familiar to you, the knowledge you have acquired is largely preliminary to the knowledge which you will be expected to possess. The greater school of experience opens its doors to you, and its masters will not be so thoughtful of your feelings as the ones from whom you part today. What you will learn in the future will be learned by experience and sacrifice. Remember what the sacred writer says: "Nothing that is of value can be done without labor and courage." "Every work that

he began he did it with all his heart, and prospered." High ideals have been placed before you, the history of your science has made you familiar with the names of illustrious and good men. Remember that the best memorial you can leave after you is a world made better by your lives. "Whatsoever thy hand findeth to do, do it with all thy might." Aim to live to excel in your profession, aim to honor it by a life of virtue and fidelity to the ideals of one of the most honorable of all callings. Remember that one may deceive the world, but he cannot deceive his own conscience; that the unscrupulous and dishonest frequently grow rich fast, but as has been said by a noted writer, "The gains of their roguery may remain with them, but it will be as a curse and not at blessing." Respect the religious convictions of your patients, be kind and sympathetic, be unselfish and loyal, be true to your vocation, and you will be true to the humanity to which you consecrate your lives as physicians.

You are entering a noble profession, in which you will find an army of as devoted and unselfish men and women as are anywhere to be found on earth. Be among the best, bring your influence for good, and never forget the responsibility which falls upon you when a life confides itself to your keeping. May the ideals you form ever be before you to encourage and inspire; may your welcome to the profession of physicians mean for you determination for the highest integrity of character and the fullest knowledge of your duty.

## LUES AS A FACTOR IN GENERAL PRACTICE.\*

BY GEO. L. COLE, M. D., PROFESSOR OF CLINICAL MEDICINE, COLLEGE OF MEDICINE,  
OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

It might be suggested that a paper upon this subject should be placed in the section of Genito-Urinary Diseases, and that the topic should be presented by a

specialist in this line, but, upon reflection it occurred to me that all of us who have practiced medicine thoughtfully for nearly two decades, have nec-

\*Read before the Thirty-sixth Semi-annual Meeting of the Southern California Medical Society, Arrowhead Hot Springs, May 2, 1906.



essarily seen many interesting cases of Syphilis and other disorders so influenced by Syphilis, that after all, possibly a free discussion by general practitioners as well as by the specialist may result in benefit to us all.

I feel justified therefore in prefacing this article by a few short general statements to which I presume all will agree. First, he who has not a fair knowledge of the symptomatology of Syphilis in its various stages is illy fitted to practice general medicine. Further, the successful man must necessarily recognize the beneficial influence of anti-syphilitic medication when indicated and intelligently administered. And again he who is most alert for evidences of both acquired and congenital taint of lues, other things being equal, will meet with the greatest number of victories in the treatment of many chronic invalids.

Many of us fail to soon enough appreciate the fact that Syphilis like many other infectious diseases, exists in various degrees of virulence; from a disease so mild as to run its course untreated and unobserved, to one of so great virulency as to be nearly uncontrollable by the most rationally directed medication. In this regard it may be favorably compared with Diphtheria and Scarlatina. Like these diseases, an apparently mild infection when transplanted upon the more prolific soil may develop into the severest type of disease.

As the unrecognized case of Scarlet Fever may later on develop nephritis which destroys the life of the individual, so milder types of Syphilis later, and much later, in life may develop lesions of the nervous system, or in fact may attack nearly any tissue formation and thus cause invalidism or destroy the life of the individual.

While we all grant these early light forms with late severe manifestations, are we all ready to recognize the severe, almost fulminating type where the

primary, secondary and tertiary lesions follow in such quick succession as to show a clinical picture of all stages manifesting themselves at one and the same time? This has been reported by practitioners of the South as being especially true in the African Race.

Have all of us learned to be equally watchful for evidences of lues in all classes of society? While we grant that usually the bartender is more frank and truthful in disclosing to us his past and present history, than is the clergyman, yet do we look deeper to see why naturally we should expect this to be the case, and thereby recognize the necessity of delicacy and adroitness in securing the confidence, which will enable the religious enthusiast or moralist to lay before us the evidence of his infirmity? It is not always hypocrisy used as a mantle that screens past errors, but sometimes a deep conviction that death might better come than acknowledge the mistake of an hour that has been followed by years of attempted expiation. One of the most useful tactics that I have found in enabling the patient to recall forgotten (?) incidents is to quietly remark that could we establish a clear history of a former syphilitic infection, the prognosis would be changed from a fatal or doubtful one to a prognosis of prompt and complete recovery, giving at the same time a concise and brief explanation of the rationale of such a statement. It is most interesting to notice under these circumstances how a few days' meditation by the patient will often result in evidence that points clearly to a primary lesion. On the other hand, I have known an intelligent man, enjoying all the luxuries of life and the blessings of a devoted family, go down to the grave declaring he had never contracted Syphilis, when, after death, I have met the physician who treated him for primary and secondary lesions earlier in life, and who previously informed the



patient of the nature of his troubles. In this case, I have never been able to satisfy myself wholly as to whether he regarded the statement of the former attendant as unreliable, or whether he intentionally endeavored to deceive me.

It is some of these phases of the apparent incongruity of the human intellect that we must at times consider, as well as the ability to interpret obscure markings of the various manifestations of the disease.

With regard to Syphilis in the newborn we are all familiar with the "Little Old Man" appearance of the baby at birth. But do we all recognize as of even still greater importance the markings which usually occur between the 3d and 12th week after birth, and which point just as clearly to congenital taint as does the appearance before described as occurring at birth? Are we all ready to recognize the snuffles with or without the sero-purulent or bloody discharge from the nares? Are we all prepared to recognize the eruption that appears usually about the nates and the eczematous condition that so often appears in this locality? This condition accompanied by fissures about the lips and at the angles of the mouth produces often a well-marked secretion of infectious material. In this condition do we recognize the fact that other members of the family may become infected from the syphilitic child? Do we remember that at this period an enlarged spleen is usually of more diagnostic importance than an enlargement of the liver?

Do we recognize sufficiently well the fact that infants treated successfully in this stage, and developing into apparently healthy children are especially prone to show evidence which may be recognized at the time of puberty? We all know something about the Hutchinson teeth. But do we recognize the prominent forehead, asymmetrical skull, the nose which has been changed

in appearance from the normal and are we ready to recognize the interstitial keratitis which is often spoken of as beginning "as a slight steaminess of the cornea," presenting the appearance of ground glass? Do we remember that not only the eye may be affected but that ear affections and bone lesions may show at this period of life? As to the question of the transmission of Syphilis to the 3d generation, there seems to be, and probably always will be, some difference of opinion, but it is sufficient to say that the best authorities are very careful in making the positive assertion of the transmission of Syphilis to the 3d generation. On the other hand, doubtless, nearly all of us have observed healthy children in which one or more of the grand-parents have been syphilitic.

Some of the most interesting cases that have ever come under my observation, as is doubtless the experience with all of the older practitioners, are those cases manifesting the very late evidences of Syphilis. As an illustration of this type, I may plainly cite the following case: In 1892, R. H., a male, 46 years of age, came to me complaining of persistent headache, coming on late in the afternoon, but being absent upon arising in the morning. Having formerly lived in a malarial country he was put upon moderately large doses of quinine, with some of the coal-tar preparations to relieve temporarily the severe pain, and told to report in a couple of days. Instead of reporting promptly at the appointed time, he appeared a week later and said that he found some temporary relief, but again his headache was as bad as before. He went on in this way for a month, at times better, at other times suffering excruciatingly, appearing irregularly for treatment, until several weeks later, when I was summoned to his home, finding him in a severe convulsion lasting something like an hour, with clonic spasms of the

right hand and arm, relieved only by the administration of chloroform. On the day following there was a partial paralysis of the right thumb, index and second fingers, thus locating definitely the cerebral lesion, more or less cloudiness of the intellect and some defect of speech. This patient was placed upon 180 grains of potassium iodide daily, and the dose gradually increased to 300 grains, with marked improvement. Inside of six weeks from this occurrence the patient returned to his store and superintended his business. Only after his improvement was shown from the iodide did he remember the fact that some fifteen years before he had an initial lesion, which was followed by a short course of treatment, a few months only. He was the father of as healthy and bright a child as I have ever seen, the child having been born some five years previous to his cerebral manifestation of the disease, and showing no evidence whatever of syphilis. It has seemed to me that we as a profession are too apt to look upon healthy, robust children as an evidence that the parents have not previously been infected with syphilis. We forget that after a period of a few years the syphilitic may produce apparently healthy children, liable at adolescence and maturity, it is true, to develop symptoms, while later in life the father or mother may show tertiary lesions.

The case above referred to seems too common to be reported in this connection, and yet the following case of intracranial syphilis came to me after several weeks' treatment by a very intellectual practitioner, who apparently did not recognize the true nature of the case:

J. H., aged 39, came to me for a severe headache; indeed a severe pain in the head from which he had been suffering for weeks. He had been under treatment, but getting worse continually. When asked if he had ever had

Syphilis, he said that he had been told so nine years before, that he was treated two months only at that time and had been perfectly well since. When questioned about his primary lesion, it was found that he had left his source of infection in Honolulu, and the sore had appeared 37 days later upon his arrival in California in a sailing vessel. Large doses of the iodide very shortly relieved the cerebral pain. Nothing had occurred during the nine years to remind him in any way of his infection.

Colle's law, namely, that the syphilitic child may be born with the mother immune to infection from it, while it may infect others, has a bearing in general medicine. I fear we are too often influenced by the fact that we have a healthy mother. In considering the probability of a syphilitic child in any instance where we know the father to have been syphilitic a few years before marriage or before the birth of the child in question, the perfect health of the mother is no proof whatever against syphilis in the child. Colle's law while having been many times attacked, and while perhaps there have been a few exceptions, which have nevertheless been so few as to aid in proving the rule, stands on as firm a foundation as when laid down by Colle.

Some interesting cases of ascites which were first thought to be the result of an ordinary cirrhosis of the liver, but yielding to large doses of potassium iodide have come under my observation, several of which have been previously reported. In one instance there was a complete recovery for a period of twelve years, after 35 tapplings. In another instance an apparently perfect recovery for 10 years, after 15 tapplings; both patients having appeared to be absolutely past recovery at certain periods of their treatment for ascites.

While it would seem that the later

evidence as shown by manifestation in the throat ought to be easily recognized, yet it not infrequently happens that the appearance of the throat may be such that a diagnosis of tuberculosis may be made. This is impressed upon me by a recent case coming under my observation, which together with the general appearance of the patient and the fact of no known acquired taint was suspected to be tuberculosis. For several weeks the case was seen by a number of very shrewd diagnosticians, some of whom were specialists in tuberculous troubles. A culture for Diphtheria was taken and scrapings for tubercle bacilli were examined. The patient, an intelligent man, who had studied medicine two years, and a graduate in veterinary science, had no knowledge of a primary lesion. Under mercury and potassium iodide, in 30 days the throat was transformed from an apparently serious condition to that of a normal throat.

We are often placed in a position of much responsibility when asked how soon a patient may marry after contracting Syphilis. To me it seems best to place the responsibility directly upon the party himself. Syphilographers differ materially in time, usually placing it from two to five years. The severity of the case and the thoroughness of treatment are important factors. The position of Edward L. Keyes in this matter has seemed a safe one to me. He says "Marriage of the male, may, in my opinion, always be safely sanctioned five years after the date of chancre, if the patient shall have been submitted to a prolonged, thorough mercurial course during said five years."

Another point of importance to the general practitioner, as to all others, is that we must more and more come to recognize the fact that Syphilis is often innocently acquired; perhaps no one has done more to emphasize this fact than L. Duncan Bulkley, of New York. As

long as we look upon Syphilis as being acquired only through prostitution and illicit intercourse, so long shall we surround it with a feeling of delicacy in questioning many of our patients concerning it. But when we come to remember that a large proportion of cases are acquired innocently through the medium of drinking utensils, and in many of the other various ways that have been pointed out by Bulkley and others, we shall come to place it upon a broader basis and thus approach it from a different standpoint. In closing, I cannot do better than to quote freely from an article by Bulkley, which first appeared in the *International Medical Magazine* and which later, in 1902, was incorporated with a booklet by E. B. Treat and Co., "*Syphilis—A Symposium*." In concluding his article he says: "First: Syphilis is certainly not a venereal disease in all cases, and the absence of any history of sexual exposure should never throw one off the guard, when there is reasonable evidence of the existence of the disease. In addition to the large number of instances of innocent marital and hereditary syphilis, there are a certain number of cases of extra-genital chancre, which must always be reckoned on when confronted with possible syphilis. Among a large number of cases of chancre which I collected from the clinics of Europe, extra-genital chancre was found to make nearly 6 per cent. among the males and almost 12 per cent. among the females. Fournier, of Paris, found that in his private practice about 25 per cent. of the females had acquired the disease in a perfectly innocent manner, while in my own private practice a careful study of the notes of cases shows that in 50 per cent. of females syphilis was innocently acquired. Allusion has already been made to the fact that in my experience extra-genital chancre is more common in males than in females. The



question, therefore, of venereal exposure need not always be of importance in acquiring syphilis, and often those of the purest character may require careful and prolonged anti-syphilitic treatment.

"Second: Syphilis is often a very erratic disease and it is sometimes difficult to get a satisfactorily corroborative history. Not only may previous symptoms have been prevented or held in check by treatment; but even if left to itself some of the early manifestations may be very slight and escape notice, yet be followed by serious lesions. This is particularly the case in women.

"Third: Many cases of unrecognized syphilis have very severe later symptoms, involving great destruction of tissue and severe lesions of internal organs. This is due to the absence of previous controlling treatment. It has been a common remark that syphilis acquired by means of an extra-genital chancre was apt to be of very severe character. It is furthermore these cases which are often overlooked.

"Fourth: Syphilis is such an imitator of other diseases that its presence may often be suspected when they present unusual or peculiar features. In such cases, careful study and analysis will often serve to determine the true nature of the trouble, but it may be difficult to obtain a perfectly satisfactory corroborative history. In many instances of late syphilis from innocent infection the sufferers do not at all suspect the nature of their disease.

"Fifth: As many of the late, often unrecognized, lesions of syphilis are the result of imperfectly treated early syphilis, it is desirable that the general practitioner and the laity be thoroughly convinced of the necessity of careful and prolonged treatment to cure the disease. Too often syphilis is treated in a superficial and hasty manner, which is neglected as soon as the symptoms disappear. According to all modern expe-

rience and opinion, this is wrong, and physicians should see to it that patients receive treatment for at least two years, in the manner now accepted and fully described in writings on the subject.

Syphilis is a great, a very great disease, much more common than is supposed by many, and is worthy of the most careful study and consideration. While its manifestations are sometimes difficult to determine, there is no reason why with sufficient care and patience in its study and treatment there should not be fewer cases of unrecognized syphilis in general practice.

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#### DISCUSSION OF DR. GEORGE L. COLE'S PAPER.

DR. C. W. GIRDLESTONE, Riverside:—Diagnosis is very important in syphilis, and the diagnosis in the third stage is not always easy. The one-time importance attached to rashes is no longer held to. Headache, especially the nocturnal form, is frequent in syphilis. Believed that epilepsy occurring after the age of 35 was generally due to syphilis.

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DR. JOHN C. KING, Banning:—As a rule the diagnosis of syphilis was easy to the specialist, because the presumption is in favor of that disease when the patient seeks the specialist. In general practice the diagnosis is often extremely difficult. Recalled the case histories of two patients with syphilis of the lung. No disease responded more to personal and general hygiene than syphilis. Out-of-door life predisposed to mild attack, while infection in a patient who had been leading a sedentary life usually meant syphilis in a severe form.

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DR. C. LEE KING, Pasadena:—Reported two case histories, one in which no initial lesion could be traced, and one in which a diagnosis of tuberculosis of the lung had been made.

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DR. D. B. VAN SLYCK, Pasadena:—Felt that latter-day treatment of syphilis was too often an overdone treatment. Mercurial poisoning was to be dreaded almost as much as the disease itself. Syphilophobia was also to be fought against. There was a tendency to give too much mercury, and not to allow sufficient resting periods.

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DR. GEORGE W. LASHER, Los Angeles:—Agreed that it was necessary to be on the alert for this widespread disease. Recalled two recent cases with sore throats in which la grippe had been diagnosed. Remembered another case in late stage where diagnosis of

cancer of the tongue was made. Felt that a patient who had had syphilis should always remain under observation.

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DR. H. G. BRAINERD, Los Angeles:—In two groups of patients diagnosis and treatment are quite different. First, women who were inno-

cent victims and yet suffered from late cerebro-spinal syphilis. In such patients, with persistent headache and anaemia, K.I. was indicated. Second, tuberculous patients who had also acquired syphilis. The temperature, which was lower in syphilis, was a great aid in diagnosis in these cases.

## THE HISTORY OF STOMACH SURGERY.\*

BY J. DE BARTH SHORB, M. D., LOS ANGELES, CAL.

Even at the beginning of this century gastric wounds were considered necessarily fatal. Not only were surgeons timid about the almost unavoidable peritonitis, but there existed a universal belief that the solving and peptonizing action of the gastric juices prevented the wound from healing. The observation that undoubtedly gastric ulcers had, and that gastric fistulae produced by physiologists in animals healed spontaneously, and that gastrotomy and gastrostomy performed in pre-antiseptic years had not shown the corrosive effect of the gastric juice, paved the way for experiments by Gussenbauer and Von Winniwarter, proving that gastric wounds sutured healed as a rule without interference from any digestive action of gastric juice.

Doctor Phineas S. Conner of Cincinnati probably did the first authentic total extirpation of the stomach in December, 1883, patient dying.

According to Rydygier, a surgeon named Torrelli in 1878 accomplished the first gastric resection in man, removing a piece 16 C. M. long, that had prolapsed from an abdominal stab wound. In the same year Billroth effected the healing of a gastric fistula by exposing the stomach and suturing it. In January, 1881, Billroth executed the first successful resection of the pylorus for carcinoma. The first total resection for ulcer was performed by Rydygier, and the first

partial resection for ulcer was made by Czerny in 1882—both were successful.

Gastro-jejunostomy was probably performed for the first time by Wolfler in 1881. Billroth followed with an unsuccessful attempt—patient dying with constant emesis. In 1883-1885 Courvoisier and Von Hacker devised posterior gastro-enterostomy—in 1897, Schlatter total gastrectomy.

The history of the evolution of gastric surgery, and of the evolutions through which each individual procedure has gone to reach its peculiar perfection is of interest, but it is not the purpose of this paper to go exhaustively into this question, and the time and place prohibit it.

LIMITATIONS OF THE INTERNIST AND SURGEON. The question of where the surgeon's function begins in diseases of the stomach, and where the internist's stops, is another interesting subject.

The history of appendicitis and gallstones is significant; these conditions have simply resolved themselves into questions of diagnosis. The diagnosis made, the case becomes a surgical one, and is this not the destiny of structural diseases of the stomach and of chronic gastric disorders not dependent on pulmonary, cardiac or hepatic disease, but chronic disease of the stomach *per se*?

SPLANCHNOPTOSIS. Ptosis of the abdominal organs, the constant dragging upon vessels and nerves bringing about

\*To have been read before the Medical Society of the State of California, at San Francisco, April 19th, 1906.

certain changes in the circulation and innervation of organs and impairing the proper drainage of others, presents a complex picture. The underlying causes for ptosis are still in dispute.

Glenard suggested: Weakness of the abdominal muscles, a loss of intra-abdominal pressure tone permitting the stomach, intestines, kidneys, etc., to sag out of place; childbirth; the improper wearing of clothing; rapid emaciation; general exhaustion, etc.

Congenital theory: Glenard states that, 23 per cent. of female bodies at the anatomical laboratory at Kiel in one year exhibited a downward displacement of the kidney; the following year nephroptosis was found in 28 per cent.

In a series of 227 women in Boston City Hospital, Larrabee found 112 cases of movable kidneys, representing 41.5 per cent.

The normal abdominal tension is diminished; the traverse colon is loosened usually at the hepatic flexure, and sags downward; it crowds the coils of the small intestines so they in turn press upon the pelvic organs, with the loss of abdominal tone.

The whole colon tends to collapse. This collapse extends even to the rectum, so there is no longer a dilated rectal ampulla behind and below the uterus. The muscles of the pelvic floor lose their tone; the uterus settles and the coils of the small intestines are crowded still further into the pelvis. The stomach follows the intestines—no longer receiving its normal support. The stomach sinks, leaving the aorta uncovered for several inches, so it may be palpated, and is often seen to pulsate. Ptosis of the stomach may exist without giving symptoms of dyspepsia. These cases must be studied carefully, if we are to recognize the difference between ptosis and dilatation. In cases of this description pyloric stenosis may exist as a result of the attached pylorus and the

prolapsed stomach forming an acute angle.

Many operations have been devised for the relief of this condition. Beyea has shortened the gastro-hepatic ligament. Sutures are so passed as to bring the pylorus close up to the under surface of the liver; the first suture includes both the capsule of the liver and the outer coats of the stomach. The gastro-hepatic ligament and the lesser omentum are infolded so as to raise the stomach, and cause its upper border to resume the normal position.

It has been suggested that the colon should be drawn up, or the stomach will lack its old support. Many suspension operations have been devised. Gastro-enterostomy and Finney's operation securing good drainage of these stomachs seem to yield good symptomatic results.

GASTRECTASIS. Ewald says: "Functional dilatations are always of relatively short duration, so that they do not lead *at all* to the classical symptoms of dilatation of the stomach, or only do so transiently."

They run the course rather of dyspeptic conditions, gastritis, atony or neurosis. Ewald says further: "I understand dilatation of the stomach or gastrectasia to be that condition of the viscus accompanied by clinical symptoms of disturbed gastric functions due to an enlargement of the organ and megastria; the acquired or congenital large stomach, the abnormal anatomical state of which is functionally compensated.

The large stomach may become catarrhal and its owner dyspeptic, but clinically speaking such a patient has no gastrectasia, although more disposed thereto than others.

Megastria and gastrectasia are frequently confounded, and are entirely different conditions. Gastric insufficiency may frequently lead to symptoms of gastrectasia, yet does not have the



anatomical basis of the dilated stomach, but is a functional disturbance.

From reviewing the literature on the subject, acute dilatation is a rare and transient disorder. Chronic dilatation probably having for its most common cause obstruction of the pylorus; second assigned cause being want of proper expulsive power. To this class belongs the so-called atonic dilatation of the stomach.

According to H. W. Welch the extent of the dilatation in this form averages much less than where the condition is due to pyloric obstruction. Mumford's conclusion as a result of his investigations leads him to believe that atonic dilatation is much less common than generally supposed. He finds adhesions, duodenal, hepatic and omental, most often account for the symptoms attributed to atonic dilatations. He has found small scars of completely healed ulcer in cases which in life or before operation were diagnosed as cases of dilatation.

In the light cast by modern surgery upon the subject, it has been demonstrated that the old idea that cancer was the most common cause of pyloric obstruction is incorrect. That although cancer is common, the pylorus ulcer with its sequelar cicatrices and perigastric adhesions plays the most important role.

Osler points out the frequency of hypertrophy of the coats of the stomach in the pyloric region as shown at autopsy.

Gall-stones associated with marked gastric hyperacidity and pyloric thickening has been relieved by removal of the stones.

Other causes for pyloric obstruction are pressure of tumor from without, and polypoid growths choking the pylorus. Volvulus, strangulation and kinking may be factors.

The medical treatment of gastrectasia has not been attended by very brilliant results. Taking the results of fifteen

years in Massachusetts General Hospital, of 117 cases of dilatation of the stomach some 57 could not be traced, and the 60 cases traced gave the end results as follows:

Well 7; unimproved 19; improved 5; dead 29. These were not old people, the average being 40.3 years. A mortality of nearly 50 per cent.; 1 out of about every 15 cured and 5 relieved out of 53.

I believe cases of atonic dilatation logically belong to the internist first, and the surgeon as a final resort to correct the structural results.

I was very forcibly impressed with a case of dilatation with simple hypertrophy of the pylorus that I saw at Mayo's. She had been treated and discharged as cured by six competent gastrologists. Their curative measures continued until they did not work any more, and she tried another gastrologist. A little woman whose hemoglobin was down to 25 per cent., and whose poor little body showed the most marked emaciation, suffering from a nearly occluded pylorus.

ULCER OF THE STOMACH. It has been stated that of all lesions giving rise to digestive disturbances, ulcer of the stomach and duodenum holds the first place.

W. H. Welch (in *Pepper's System of Medicine*, 1885), estimated 5 per cent of mankind to suffer from gastric ulcer.

Berthold found 262 cases of ulcer in the Pathologic Institute of the Berlin Charite in 15 years, representing 2.7 per cent. Nolte found 1.23 per cent. in Munich Pathologic Institute; Massachusetts General Hospital a little over 1 per cent.; Hopkins 0.32 per cent.; Cook's County 0.15 per cent.; Fiedler examined 2200 bodies, found 20 per cent. in females and 1.05 per cent in males.

Geography seems to have a great deal to do with ulcer of the stomach. Statistics show 2.7 per cent. for Berlin; 1.23 per cent. for Munich; 8.3 per cent for

Kiel; 10 per cent. for Jena; 13 per cent. for Copenhagen.

As to results of medical treatment of ulcer of the stomach, taking the figures of Greenough and Joslin, of 187 cases studied and 114 cases traced, after leaving the hospital the end results in five years show 40 per cent. cured, 36 per cent. not cured, (recurrence) deaths 20 per cent. Of these 114 cases 80 per cent. were discharged from the hospital as cured, but at the end of five years only 40 per cent. remained well. These statistics about agree with other compilers according to Mumford, who has gone exhaustively into the question.

The surgical history is too recent to elaborate long statistics. The convictions of Mikulicz, Hartman, Kocker, Mayo, John Deaver and many others worthy of respect should be considered. Kocker says, "The majority of practitioners do not sufficiently realize what brilliant results are to be obtained by operative measures in chronic affections of the stomach, commonly known as gastric catarrh. Not only can the dangers of ulceration such as hemorrhage, perforation, transition into cancer be prevented, but the disease and its results may be rapidly and certainly cured, that the medical treatment of obstinate cases must be put in the background. In *Operative Surgery*, 1903, Hartman gives the end results in 20 cases followed from one to four years:

Pylorectomy 1 case well after 2 years; gastropexy 1 well after 2 years. Gastro-enterostomies 18; 16 well after 2 years; 2 were markedly relieved.

Rodson and Moynihan give their mortality 3.2 per cent in their last 218 operations for non-malignant disease; Mayo in 1902-89 gastro-jejunostomies with a mortality of 7.8 per cent; 28 Finney's 3.5 per cent.

Kocker further states, "The pain in the stomach disappears immediately after the operation; that is the invariable rule." The patient does not require to

pay any further attention to the nature of the food; the vomiting disappears; the bowels become regular; repeated investigations of the gastric contents show that there is a progressive improvement in the process of digestion. Hyperacidity diminishes, if too little acid is present, it becomes increased. Stendel, Carle, Fantino, Hartman, Soupault and Mintz agree with this conclusion.

"The flow of bile into the stomach has no deleterious influence either on the health of the patient or on the function of the stomach." "Operative treatment of the results of ulceration is the one cure for this frequent and serious disease." Hartman and Soupault agree with Kocker that the flow of bile and pancreatic juice into the stomach has no deleterious effect.

Operations for the relief of ulcer of the stomach consist of resection of the ulcer implication or infolding and gastro-jejunostomy. The difficulty of determining the exact position of ulcer is great. Ulcer is so often multiplied and simple erosion may be of such a character as not to be discernible at operations but may give rise to alarming and even fatal hemorrhage. Gastro-enterostomy seems to fulfill all indications in the majority of cases.

CANCER. According to Von Mikulicz and W. M. Mayo, one-third of all cancers are found in the stomach, and 2 per cent. of all deaths are due to cancer of the stomach. Von Mikulicz says, "7 per cent. follow old ulcer." Graham (Mayo's Internist) says, "Of one hundred and forty-five cancers of the stomach that came to operation in our hands we found a previous history of ulcer in 60 per cent.

Mumford has studied 50 cases of cancer of the stomach at the Massachusetts General, and 41 of these cases gave a history of ulcer or long continued gastric trouble.

Since Cunco and Most demonstrated the lymphatic connections of the stom-

ach, the lymphatic isolation of the dome of the stomach, "the fact that in 4 to 10 per cent. of cases no metastasis has been found, and the enlarged glands were merely hyperplastic, offers some encouragement for operative efforts."

Time will not allow me to go further into this question. Study of statistics would show a prolongation of life by operation and a very few cures, much as statistics of cancer elsewhere. It is to be

hoped that the solution of the cancer question may be solved by the correction of pre-cancerous conditions.

Stomach surgery from an economic standpoint I believe to be worthy of consideration; the saving of time and labor are important factors. Instead of months and years of treatment and invalidism, the patient after a successful operation is able to resume work in a month's time.

## THE INDUCTION OF LABOR.\*

(WITH A REVIEW OF 181 CASES OF INDUCED LABOR AT SLOANE MATERNITY HOSPITAL, NEW YORK CITY.)

BY PAUL ALLEN ADAMS, M. D., LOS ANGELES, CAL., RECENTLY OF THE SLOANE HOUSE STAFF.

The three non-cutting operations for dystocia most often employed are Induction of Labor, Forceps and Version. The last two are limited in their application to the latter weeks of pregnancy, while labor may be induced at any time after the occurrence of conception.

The induction of labor divides itself naturally into two parts:

I. Induction of Abortion, which is the artificial production of labor at any time before the seventh month and the viability of the child.

II. Induction of Premature Labor or the emptying of the uterus after the seventh month when the child is viable and the interests of both mother and child must be considered.

Abortion is justifiable when either the mother or the child is in danger.

The indications on the part of the fetus are usually some abnormality of the membranes as cystic degeneration of the chorion, acute polyhydramnios, placenta previa, accidental hemorrhage from a normally situated placenta, and fetal death from any cause.

The two most common maternal indications are pernicious vomiting and

threatened eclampsia with increasing albumen and the evidences of toxemia. Less common indications are albuminuria, toxemia, *increasing* disease of heart or lungs, chorea, pernicious anaemia, mania, melancholia, and any condition which may necessitate Cesarian section as tumors, deformities, etc.

The methods of procedure in inducing abortion are as follows. Drugs, vaginal tampons, electricity, etc., should be abandoned as they are too slow and are inefficient and dangerous. Two well recognized methods are now in use.

A. Mechanical dilatation of the cervix and emptying of the uterus at once with finger, curette and forceps.

B. The same operation preceded by preliminary softening and dilatation of the cervix.

The first method is indicated when gestation is not past two months, while from the third month on the choice of method must be made depending upon the conditions present. Up to the second month the cervix may be dilated and the uterus emptied at a single sitting. After the second month, however, we have found it better to first pack the

\*Read before the Los Angeles County Medical Association, March, 1906.



cervix and vagina with iodiform gauze and leave for twelve hours. The cervix softens and can then be dilated and the uterus emptied by using one or two fingers.

II. In the Induction of Premature Labor we keep in mind two lives that we are trying to save.

A. The child is over seven months and indicates interference.

(a.) Where there is a large or prematurely ossified head without moulding.

(b.) Habitual death at a certain time. Here labor should be induced before this time.

(c.) Fetal death.

B. The indications on the part of the mother are

(a.) Contracted or deformed pelvis or canal. We have found that where the biparietal diameter is 9 1-4 c. m. at labor, which is a normal measurement, that at eight months this child's head was 8 1-4 c. m., and at seven months was 7 c. m. Thus can be seen the advantage of inducing labor before term in a contracted pelvis.

(b.) Tumors.

(c.) Placenta previa.

(d.) Toxemia and eclampsia.

(e.) Chorea.

(f.) Mania and melancholia.

(g.) Pernicious vomiting (toxemia).

(h.) Any grave systemic disease.

Premature Labor may be induced in several ways. Drugs should not be used. There are five recognized methods that are in general employed:

1. Puncture of Membrane or Sheele's method. Labor will proceed if we wait long enough. But it is not a good method as the labor is dry and tedious and is bad for mother and child.

2. Packing vagina with gauze. Also a slow method. The cervix usually softens and dilates. This is often combined with other methods.

3. Injection of glycerine. This is a method introduced by Pelzer of Ger-

many. One or two ounces of glycerine is injected between the fetal membranes and the uterine wall. For this purpose a catheter is attached to a glass funnel and is introduced while the glycerine is flowing so as to expel all the air. Strict aseptic methods should be employed. It may be necessary to place a sterile tampon against the cervix to retain the glycerine. This method usually works and is fairly rapid but is not without danger as it may cause hematuria and it is not wise to irritate the kidneys. The action of the glycerine is as an irritant to the mucous lining, mechanically separates the membranes, draws water from the tissues by hygroscopic action and reflexly causes contraction.

4. Introduction of Bougie. This is the quickest and most satisfactory method of inducing labor. To employ it the membranes should be unruptured and must not be ruptured during the introduction or the labor will be a dry one. Krause's method is probably the best and is as follows: A stiff silk bougie is used, and not a catheter as we do not wish air to enter, and the catheter has an eye which may be dangerous. A No. 14 Obstetrical Bougie is employed and is best sterilized by heat. If it becomes soft it may be necessary to use a stylet to stiffen it and to assist its passage into the uterus. One or two fingers are introduced into the cervix to guide the bougie between the membranes and the uterine wall. All but about two inches are inserted and this end is bent upon itself in the vagina, which is packed with sterile gauze. In from six to twelve hours labor will usually begin.

5. Mechanical dilatation of the Cervix. If the bougie does not bring on labor within twelve hours we may introduce a fresh bougie or put in an elastic bag. Where the physician can stay with the patient a bag is often used alone. It has the advantage of softening the cervix more quickly than by any other means. The bag is left in until

labor is well advanced. If dilatation is delayed traction may be made on the stem of the bag every fifteen or thirty minutes to hasten matters.

Dr. E. B. Cragin, Professor of Obstetrics and Gynecology in Columbia University and Attending physician at Sloane Maternity Hospital, states that he often uses the bougie to be followed by bags and that the combination of the two works very well.

The use of bags is indicated:

1. To induce labor as in cases where the pelvis is small or the child's head is large.

2. To dilate the cervix in prolonged and tedious labors especially where the membranes have been ruptured.

3. To tampon the cervix in cases of placenta previa.

4. In some cases of prolapse of the cord.

5. Bags are of great value in softening the cervix before doing an accouchement forcé.

The bag which we usually employ is the Voorhees modification of the Champetier de Ribes balloon and it gives very general satisfaction. They come in four sizes—Nos. 1, 2, 3 and 4, each bag being one finger's breadth wider than the number of the bag. No. 4 is seldom used as it is apt to displace the present part.

Bags may be introduced by sight or by touch.

1. By sight when the cervix is not dilated or only slightly dilated. A posterior retractor is put in place and the cervix is pulled down and steadied with a volcella. It may be necessary to dilate the cervix with the fingers or a glove stretcher dilator. The bag is rolled up as small as possible and introduced with a sponge holder or regular bag introducer. From one half to one third the bag is passed within the internal os, the bag is held within the cervix with the fingers and the forceps removed. When the bag is in place it is filled with a sterile solution of 1-2 per

cent. lysol and the stem is tied and turned up within the vagina.

2. By touch when the os is dilated one or more fingers breadth. The bag is simply introduced into the cervix sliding along the fingers to the internal os. The remainder of the technique is as in the first case.

In the cases of great emergency the wisest plan is to soften the cervix with a bag or a tampon in the vagina, dilate with the fingers or a glove stretcher dilator, and deliver with forceps.

Last Spring we made a study of the cases of induced labor which had occurred at the Sloane Maternity Hospital during the last few years and the following facts of interest were brought to light:

A. As to causes for the operation:

1. Deformed Pelvis, 50 cases as follows:

Justomino, 22.

Flat, 19.

Kyphotic, 5.

Obliquely contracted, 4.

2. Eclampsia, 29.

3. Albuminuria and Threatened Eclampsia, 28.

4. Accidental Hemorrhage, 8.

5. Melancholia, 7.

6. Chronic Endocarditis, 5.

7. Pulmonary Tuberculosis, 5.

8. Dyspnoea, 4.

9. Previous High Forceps with one Symphyseotomy, 3.

10. Persistent Vomiting, 3.

11. Previous Still-born children with slightly justomino pelves, 3.

12. Previous Instrumental Labor with large child, 3.

13. Overtime with large child, 3.

14. Overtime with rigid cervix, 1.

15. Asthenia and general weakness of mother, 2.

16. Hysteria, 2.

17. Prolapsus Uteri, 1.

18. Placenta Previa with one Transverse Presentation, 3.

19. Extreme Youth (13 years) 1.

20. Oedema of Lungs, 1.

21. Ruptured Membranes, 1.
22. Hemiplegia with Obliquely contracted Pelvis, 1.
23. Ovarian Cyst, 1.
24. Dead child, 1.

B. The methods of procedure adopted in these cases may be summed up as follows:

1. Dilatation of the cervix in 107 cases of which twelve were cases of accouchment forcé. Dilatation was accomplished by using Voorhees Bag in 49 cases, and manual dilatation, which in some cases was combined with the use of Goodell's or other dilators, in 58 cases.

2. Bougie (Krause's) method, 46 cases. This was in some cases combined with No. 1.

(These two are the favorite methods now in use at Sloane.)

3. Rupture of Membranes (Sheele's Method) 10.

4. Tampon of Cervix, 4.

5. Tampon of Vagina, 3.

6. Quinine, Strychnia and Prolonged Hot Douches, 5.

This is no longer used alone.

7. Dührssen's, Incisions have been tried.

8. Puncture of Labia was performed in one case because of extreme oedema of abdominal wall, vulva, thighs, etc.

9. Various combinations of the above have at times been used.

The following general rules now apply to the Sloane cases:

1. Patients all receive lysol douche for lubricating and cleansing effect before the introduction of bags or bougie.

2. All receive Strychnine Sulphate gr. 1-30 and Quinine Sulphate gr. 3 to 5 every 3 to 4 hours.

3. In the bag cases at the end of six hours an attempt is made to pull the balloon through the cervix.

4. If the patient is having strong labor pains nothing more may need to be done. If, however, it is considered best,

the next size bag or a bougie may be introduced.

#### DISCUSSION OF DR. PAUL ADAM'S PAPER.

DR. W. JARVIS BARLOW:—Not as an obstetrician but more as a Sloan man, he spoke on this paper, at the request of Dr. Adams. The methods described by Dr. Adams are about the same as were in vogue eleven years ago. Dr. Tucker at that time did not use the bags so much. The manual dilatation and bougies were the favorite methods. The advantages of the bags, especially in rigid cervix are evident. The Lysol douches are also new. In my time, the bichloride douches were used both before and after labor. Now no douches of any kind are used in normal labor. In eclampsia the mortality of the mother in my time was eleven per cent, and for the child thirty per cent. Of course many of these were bad cases and came to us almost in extremis.

Would say a word in regard to induction of abortion in increasing disease of the heart and lungs. Any active chronic disease of the lungs is the indication for the earliest possible induction of abortion. Could not believe that the rights of the child were paramount to those of the mother.

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DR. E. FOLLANSBEE:—Agreed with Dr. Barlow in regard to early abortion in tuberculous women. Many of these children were defectives.

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DR. W. W. RICHARDSON:—Felt that induction of labor and emptying of uterus should not be done at the same time.

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DR. E. M. LAZARD:—Believed that placental site should always be located before inducing labor with bougies. Preferred rapid dilatation as in eclampsia, by means of Bossi dilators rather than with bags.

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DR. PAUL ADAMS:—A consultant was always desirable in inducing abortion.

TO REDUCE STRANGULATED HERNIA.—First, relax with heat, position, chloroform or ether, then relieve the congested tumor of its contained blood by firm, gentle compression, then press it into the abdomen with the same gentle means. If you are gentle in your management, and it takes you half an hour, you will do no harm; but having once begun your pressure, do not let up on it till you are done.—*Lancet-Clinic*.



## ECONOMY IN PRODUCING AND MARKETING CERTIFIED MILK.

BY JOSEPH ROBY, M.D., ROCHESTER, N. Y.

"We desire to emphasize three points.

"First.—That remarkably clean milk can be produced without an expensive plant.

"Second.—The steps necessary to produce such milk.

"Third.—A scheme for improving the entire supply of cities.

"Physicians who have more or less devoted themselves to the diseases of children, have, as a rule, been responsible for certified milk; the certificate usually meaning a certain percentage of fat and total solids, and a low bacteriological count. What is said here will have to do only with milk of a low bacteriological count or clean milk, because we are firmly convinced from the results in Rochester, that this is much more important than high fat percentages.

"As Professor Conn of Wesleyan pointed out, it is not so much the number of bacteria in milk as it is the kind. But low counts show how the milk is produced and handled, and if there are few of any kind, of course there must be few injurious ones. Von Behring and his pupils, by feeding young animals non-virulent cultures of anthrax bacilli, seem to have proved that the mucous membrane offers practically no resistance to the entrance of living bacteria into the blood, and the frightful mortality of young infants, and the frequency with which they suffer from gastro-intestinal infections would seem to prove this for the young of man. This has led him to the statement that an infant should not receive milk containing more than 1000 bacteria to the c. c., or quarter of a teaspoonful.

"Dr. Goler's work in establishing and carrying on municipal milk stations for

supplying a clean milk for infants is so well known that any further description of it may seem unnecessary, and yet the plan will be briefly outlined in order to make the other conditions in Rochester more plain.

"Dr. Coler has established during July and August from year to year a bottling station at various milkmen's farms. This bottling station has consisted of a portable house (one of the city's election booths) erected near the stable, together with two or three tents for a nurse to live in. A trained nurse with assistants attends to this milk at the farm. All the utensils, cans, pails, and bottles are sterilized: a kerosene stove being used for the purpose. The milk is taken to the bottling room and run directly into nursing bottles, four strengths being put up: First, whole milk, and three different dilutions of whole milk with sugar solutions.

"These bottles are then packed in ice and delivered to the distributing station. The distributing stations have been in an old schoolhouse, used as a police station; hardware stores, bakeries; in fact, any place where there was room for an ice-chest. A trained nurse is in charge of these stations, and gives advice to the mothers, and weighs the babies.

Since the establishment of these stations, and a more efficient milk inspection, the death rate in children under 5 has markedly decreased; not only relatively to increased population, but absolutely.

"In 1904, the milk stations were unusually popular, and there were many protests against closing them, and we found ourselves with a considerable number of infants demanding a clean

milk, which they were unable to get for love or money. That is to say, there was no one in Rochester producing a milk that could be depended upon to run below 100,000 bacteria to the c. c. A great many men would occasionally have counts of 75,000, 50,000, or even 10,000, and the next month they would get over 500,000.

"The average monthly counts in Rochester for the last six years vary from about 100,000 per c. c. to about 500,000 per c. c. in summer.

"Milk is supplied to Rochester very much, I imagine, as it is to other cities of the same size. There are four or five large dealers who get railroad milk and put out 1000 or more quarts; small dealers getting railroad milk, and other small farmers who produce and peddle their own milk.

"In spite of the continued object lesson of these stations to the milkmen (for the portable bottling and sterilizing plant has been located at a different farm almost every year) in spite of the opportunity for the milkmen to see how anxious the people are to get a clean milk, and in spite of an invitation from the Academy of Medicine to them to get their milk certified, until this year no one has been found who would do it. In November, 1904, a bulletin containing about such advice as is given later in this paper, warning them about scarlet fever, diphtheria and typhoid and offering to give a rebate to assist in purchasing sterilizers, was sent to every milkman. Then in order to get some milkman to produce a real clean milk, a letter was sent to about twenty men who had had rather low bacteriological counts and who produced their own milk, for, of course, those who bought their milk could not control its production. This letter simply asked them to come into the health office. Then it was explained to them what it was necessary for them to do, and on our parts we said that we would try to

get twenty people who would agree to take a quart of milk at the advanced price of 9c a quart, 6c being the usual price in Rochester.

Much to our disappointment we have never had a single order for the sterilizers, and we could only find one man who was willing to try to produce unusually clean milk, for we had at least hoped to be able to divide the city into quarters, and have one man for each quarter, so that the man's route would not be too long. Mr. Lovett, who qualified, had been working for a man who had formerly been in the milk business, and when he decided to sell out, Mr. Lovett rented the farm and bought his route, so that he started with no capital and on borrowed money. The barn, although one of the best cow barns in Monroe county, is a very ordinary one. The main building being two stories; basement of stone and partially underground on one side and upper part very rough boards, with a new, but inexpensive wooden cow barn attached so as to form a T. There were no cement floors. There was an inexpensive wooden milk room, with wooden floor, situated about thirty feet from the barn. Fortunately the man had a steam boiler, and had constructed a metallic lined wooden tank for cooling the milk. This tank was converted into a sterilizer by making the cover fit tightly, and running the steam pipe into it, so that a temperature of 212 degrees could be easily obtained, and all the utensils sterilized. The cattle are ordinary grade cows with a few Jerseys, but all tuberculin tested.

The directions embodied under point 2, were given, and numerous trips to his farm have been made to see that he was carrying them out.

The milk is poured from the milking pails into the bottle filler; the bottles filled, capped and sunk in ice water. No aerator is used. In well-equipped modern dairies these may work all

right, but we have been afraid to advise it, unless one could control the air in the milk room rather better than seemed possible here, and it seemed to us one more chance for infection. We think that we have also killed the dreaded animal heat bugbear. We have not talked to a single milkman who has not held up his hands in holy horror at the idea of putting a tight cover on milk while it was still warm. And yet this can be done, and there will be no animal odor if the barn is clean. If milk produced in this way is kept cold at 45 degrees, it will keep sweet almost indefinitely. A quart of milk was opened every day to taste it, and it kept sweet for sixteen days, and might have kept longer had there been any left.

The bacteriological counts of Mr. Lovett's milk in 100 examinations have given an average of 3853 per cubic centimeter, or 1-4 teaspoonful, with 21 below 1000, the lowest 240, and only one (29,000) above 20,000.

Thus our first point has been proved, for he has certainly done without an expensive barn; what many another small farmer could do.

As to the second point, very long and complicated rules have been given to milkmen, and have been put down in such a way that the men have not attempted any of them, because they did not realize which was the most important. We think that the rules should be very few and arranged in the order of importance as follows:

First—The protection of the milk from infection by scarlet fever, diphtheria and typhoid.

If one of these diseases develops on the farm the patient must be immediately removed from the premises and must not come in contact with any one who has anything whatever to do with the milk. The milk room, barn and cows should be thoroughly cleaned and

every utensil must be sterilized by steam.

In case of diphtheria every one on the farm must have an immunizing dose of anti-toxin.

These rules should be strictly enforced and the dairyman must be made to report these diseases to the Health Office; failure to do so either wilfully or through ignorance should mean a permanent revocation of the license. If no other place is available, cases of these diseases should be removed to a hospital, even at the expense of the municipality.

Second—Cooling the milk and keeping it cold: At least below 50 degrees. At first thought, all might not agree to this being so important, but on reflection it will be self-evident. Practically, at least, sterilized milk cannot be draw from the cow; so we start off with an excellent culture material already infected, and if allowed to stay, or get warm, these bacteria multiply beyond comprehension, so that a milk containing 3000 per c. c. in the beginning would at the end of twenty-four hours contain many millions, and be infinitely worse than one containing 30,000 at the start, that had been kept cold all of the time, for if kept very cold the bacteria would not increase much, and might be even less in twenty-four hours.

Third—Keeping the utensils clean, or better, sterile, is about as important as number two. Milkmen must be made to understand that their "scalding" is not as efficacious as actually boiling water in the utensil, or submitting it to steam under pressure for some time, and that nothing like real clean milk can ever be produced unless the vessels are comparatively sterile.

Fourth—Milking directly through sterile cheese cloth into a pail with a small (five inch) opening. On some thirty comparative counts, versus the



open pail at the milk station during 1904, this cut the average count exactly in half. Cheese cloth covers must be changed at the time pail is emptied.

Fifth—Keeping milk tightly covered. These five points absolutely necessary, and without following them, milk with few bacteria cannot be produced. Milk produced in this way will probably run about 10,000 to the c. c. Now every one of the subsequent points that are followed will reduce the count a certain amount so that in perfectly equipped and managed dairies the count may run regularly at 1000 or below. These points are:

Sixth—Discarding the first draws from each test.

Seventh—Keeping the cow absolutely clean.

Eighth—Keeping the milkers' hands and clothes clean.

Ninth—Keeping the ceiling clean and free from dust, preferably to lath and plaster it.

Tenth—Keeping the barn clean and using shavings for bedding instead of straw.

Eleventh—Being careful not to stir up the dust just before or at time of milking.

Of course, in a barn constructed entirely of cement, seven, nine, ten and eleven can be much more easily carried out.

Mrs. Cooke of the New York commission assures us that just as good, if not better, milk can be produced in good dairies without the cheese cloth strainers over the pail. We do not doubt but that this is so. But unless the last points can be closely followed, the strainers seem necessary.

So much for the first two points and a method of getting a certified milk plant started in cities where there is no such supply. One does not have to depend long upon their personal friends

(to whom in this case we owe a great deal) for creating a demand. Mr. Lovett's trade has increased in just a year from the original twenty quarts to about 250. But what are we to do for the great mass of people who cannot afford to buy certified milk delivered in glass jars at an advanced price? We offer this scheme. Make the milking pail, shipping can and delivery can one vessel, holding about fifteen quarts, with a small  $5\frac{1}{2}$  inch opening and a tight cover. Milk through a sterile cheese cloth strainer directly into this can until it is full; throw strainers into a pail, put on the cover and sink can in ice water. This can is shipped by rail, or carried on the peddler's wagon, and is used for a delivery can. The hospitals, hotels, grocery stores and restaurants would receive their milk in unbroken packages directly from the cow without any handling.

For the house peddling we offer one of two suggestions: The usual method, using a quart dipper, or a tightly closed pail with spout that can be corked; then the peddler turns the pail upside down to mix the milk, removes the cork and pours out the required amount into the customer's glass or tin quart measure, the cleanliness of which the customer is responsible for.

This milking pail and cheese cloth strainer must be sterilized by steam, or simply by putting pail containing some water and strainers on the stove to boil for five minutes. Cooling tank should be made so that it overflows at a level just below cover of can. This scheme would necessitate a much less expensive milk room, much less apparatus and much less handling, with no bottles to lose or break, so that it ought to materially lower the cost of "clean" milk.

Mr. Lovett has tried our experiment in order to test the efficacy of this plan. As we had no special pail and no quart

dipper, the can was opened, a quart poured off and a sample for bacterial examination taken each time.

Five hours after milking .....461

Five minutes later .....no growth  
(somewhere under 277)

Ten minutes later .....242

One and one-half hours later .....200

Milk on the wagon all of this time.

Bottle milk, same day .....13,000

As in the dilution made, it only took one colony to make 242 or 200, it seems probable that 461 shows some accidental contamination and that 200 would have been the right count with a heavier dilution.

## THE WATER AND MILK SUPPLIES OF LOS ANGELES.\*

BY E. L. LEONARD, B. S., M. D., CITY BACTERIOLOGIST, LOS ANGELES, CAL.

**WATER SUPPLY:** The location of nearly every town of importance in Southern California was originally planned by the old mission fathers in relation to the possibility of its water supply. The most important missions were built in those districts where water was found in largest amount. At these old missions one may see, even today, evidences of a high degree of engineering skill possessed by these people in planning the ditches and reservoirs.

A reference to the map shows that the San Gabriel and Los Angeles Rivers carry the water from the mountains toward the sea, and although not rising directly in the high ranges of the Sierra Madre Mountains, at least a large part of the rain and snow finds its way into these two streams, through the underground washes with which the San Fernando and San Gabriel Valleys are filled. The San Gabriel River is different from the Los Angeles River in that it has a perennial flow from the mountains in which it originates, and is less affected by seasons of drouth.

The peculiar geological structure of the washes referred to shows that they are made up of sand and gravel, with the bed rock between 200 and 300 feet below the sea level. These immense subterranean filter galleries, as we may speak of them, make the character of

our water supply one of the most ideal as far as bacterial invasion is concerned. If it were possible to bring this water filtered through its beds of sand, gravel and alluvial debris directly into our city mains, then our water supply would be most ideal in quality.

A study of the differences in the total rainfall in Southern California shows great variation, 5.28 inches one year and 38.23 the next. This necessarily affects the amount of water coming through the Los Angeles River, and causes great apprehension on the part of those whose business is in any way connected with the water supply.

It is almost incredible that torrents of water coming down ravines and canyons are absorbed so quickly and disappear entirely into the gravel bed of the valley, while the river a few miles below shows no increase in volume whatever.

Under average conditions the river begins to appear about 11 miles from West Glendale. Its increase in volume is very marked, and its flow is about 25 cubic feet per second at the southern bend. At this point the first supply ditch is taken out, the water from which is used for irrigating purposes and to supply the parks of the city.

Filter galleries are now in process of construction at the head works, where the surface water is tunneled into the

\*Read before the Biological Section of the Southern California Academy of Sciences, May 12, 1906.

bed of the river and filtered through sand before entering the head works. The bacterial count of the water before entering the filtration galleries shows 130 colonies per cu. cm. even in their incompleated condition.

The total consumption of water in Los Angeles is as great as that of San Francisco—34,000,000 gallons a day in summer, 18,000,000 gallons a day in winter.

The river still increases in volume up to about a mile above Tropic. At this point the main head works of the system are built, and the flow is between 65 and 75 cubic feet. There is a slight increase in volume until Columbia street is reached, where the river disappears altogether, as the depth to bed rock increases.

During the five years in which the city has owned its water supply, the development of water has been given close attention by Superintendent Mulholland. With the idea of increasing the total supply different sets of wells have been bored and tunnels built.

The Buena Vista street wells, located in Elysian Park, and pumping to supply the gravity reservoirs on Beaudry avenue and Elysian Park, come from a 4000-foot tunnel under the river bed, and supply about 3,000,000 gallons daily. The bacterial count varies from about 41 to about 150 bacteria to the cu. cm., depending on the season of the year. In summer time the count runs higher, as the water is low. Two other wells located at the end of the West Jefferson street car line supply 1,000,000 gallons per day, and the bacterial count is between 80 and 100 colonies.

The largest part of the city water, however, is derived from the Los Angeles River. A trip to the head works occupies the greater part of a day, and at this point the bacteriological tests average from 600 to 2380 colonies per cu. cm. Above the head works to the

northeast the water is on the surface. It is in this region that the San Fernando farmers drain the river for agricultural purposes, and in years past their stock was pastured on the banks of the stream. Dr. Powers has watched this portion of the river most closely, and in years past has pulled carcasses of sheep, horses and mules out of the river. At the present time these conditions are greatly improved.

From the head works 12 miles northwest the city water runs in a cement conduit into the city mains. Between the head works and the Crystal Springs house, located on the other side of Griffith Park, the river again flows on the surface for a distance of several miles and enters the city mains at Crystal Springs house. The bacterial count at this point is between 600 and 100 colonies to the cu. cm.

Various tests of the city water made from the faucets in different parts of the city show an average of about 30 colonies to one c. c. The difference in the count is caused by the lack of nutrition and oxygen, and the pressure to which the water is subjected in the pipes.

It is commonly taught that any water supply containing over 500 colonies to one c. c. is unfit for use. You can see, however, that Los Angeles faucet water is comparatively free from bacteria. A bacterial examination of distilled water as delivered shows 100 colonies to 1 c. c., but of course weighing a matter of this kind, one must remember the kind of bacteria present is the all-important consideration. It is a possibility of course that the organisms in city water are more apt to be pathogenic on account of the pollution by the San Fernando Valley farmers and their stock, but in discussing the question of the transmission of typhoid fever through our water supply, with Dr. Powers recently, he said in the his-



tory of the Health Department he has never had reason to believe any epidemic of typhoid fever had its origin in the water supplied to the city, but rather from overflowing cesspools, cases of the disease at dairies, and the difficulty of proper sewage disposal at the beaches. About three-fourths of the cases of typhoid fever reported in Los Angeles have their origin in the country.

In making bacterial tests of water, certain general principles should be borne in mind. In the first place, the plating of the water should be done at the well, reservoir or stream to be tested. If samples are to be transported to the laboratory, they should be placed on ice. Several plates should be made from portions of one c. c. 1-10, 4-10 and 6-10 give one a good control test. In routine work agar is preferred to gelatine culture media, so that the growth may take place at a temperature above that of the room, 30 to 37½° C. The isolation of specific organisms from a given sample of water presents many difficulties. *B. Typhosus* has been isolated from water about once in 500,000 times, according to Williams. *B. Coli* is more readily found, on account of its greater endurance, and although this organism has been found in the faeces of birds and other animals, besides man, its presence in large numbers in a given sample of water is considered suspicious by many city bacteriologists.

The Owens River project opens up a bright future for Southern California. You are all more or less familiar with the plan to bring the waters of this fertile valley 200 miles northeast, in Inyo county, to Los Angeles. A clear and interesting account of the plan is given in the November number of *Out West* to which I refer you.

The matter has been voted upon, bonds are sold, and work will begin early in February on the construction

of conduits and tunnels. It is estimated that the work will require at least four years to be completed. Others estimate at least ten years will be required.

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**MILK SUPPLY:** In 1894 the work of testing the milk for butter fats was begun by Dr. Powers in Los Angeles, in the little room 6x10 in the attic of the City Hall which served as a chemical, bacteriological and milk laboratory, as well as fumigator's room, and detention ward for contagious cases for several years.

During 1894 to 1897 nothing systematic was accomplished on account of the lack of assistants. In 1897 the City Council allowed a milk inspector, who went to the larger dairies supplying milk to the city, and made systematic tests of milk for butter fats and solids. The dairymen made strenuous objection to any "interference" with their work, and said the cattle in this country couldn't produce as rich milk as elsewhere on account of the climate and feed of Southern California.

In the early part of 1898 a standard was established for 3% fats and 12½% solids. Then the long, hard work began of compelling dairymen supplying milk to the city to conform to this standard. The early part of the work was done by Mr. George Hooser, whose untiring energy did much to bring about a better condition of affairs. To put one's self in the dairyman's place doesn't require very much imagination; to be held up at some dark corner between two and three o'clock in the morning, have an inspector open the cans, test each one with the lactometer, and at last find those which had evidently been replenished from the water faucet, and take a sample, and within the next day or two bring the driver before the police court judge, was a common occurrence in those days. Such was the character

of the work, and it almost goes without saying that this particular busy milk inspector lost his job at the next election!

The work of educating these dairy owners has always been one of Dr. Powers' numerous special duties, and to his untiring zeal we owe the present fairly good condition of the milk supplied to Los Angeles. In 1905 the standard for fats was raised to 3½%; solids, 12½%, while in reality the majority of the milk tests show 4% fats with the Babcock test.

The confidence of most of the dairymen has been won, and they realize that the ordinances in regard to standards, cleanliness, etc., are for their own interests. It is gratifying to see them come to the office for advice and counsel.

With the close of this year the first systematic bacteriological work has been done on the milk supplied. 39 dairies have been visited by the City Bacteriologist, and three sets of tests made from each dairy.

At the various city depots 12 different visits have been made and 49 different dairies tested as the milk was brought into the depot. Tests have been made also of the milk as delivered to the consumer—46 specimens from restaurants and hotels were examined.

In July of this year the Board of Health established a bacterial standard for milk of 500,000 colonies to 1 c. c., after a careful study of the tests made. This has been conformed to by the better conducted dairies and the work has proved a stimulus to the majority of the dairymen. The long years of education by Dr. Powers, and the activity of the present Board of Health in visiting the dairy ranches have resulted in the use of more whitewash on the dirty corrals, more screens and cleaner milk houses and in some cases even in the washing of the milker's hands and cleaning of the udders of the cows than in several years.

There is perhaps no medium outside of blood serum which forms such an ideal culture material for bacteria as milk. It is estimated that milk 24 hours old contains more bacteria than sewage.

These are derived from the body of the cow, the hands of the milker, his pails and utensils, the water with which the cans are rinsed, the air and the flies. The temperature of milk results in a rapid increase of the number of germs, and even under ordinarily clean surroundings the number of organisms in a given sample is necessarily large.

The udder of a cow is practically free from bacteria, but the lactiferous ducts are more or less crowded with various forms.

Prof. Russell, of the University of Wisconsin, gives the following interesting figures: Foremilk, 20,000 to 48,000; Milk after removal of foremilk, 1,000 to 4,000 colonies in 1 c. c. In many of the large cities this fact is taken advantage of and certain dairies are under the immediate supervision of physicians and health boards. The cows are cleaned, milk utensils are scalded and milkers wear clean white clothing, the foremilk is discarded and the high grade product is known as "certified milk." So far Los Angeles has no concern which furnishes this class of milk, but it is believed by those who have studied the question that there is a fortune in the dairy business along this line.

Much of the milk delivered to the city through the depots is pasteurized, that is, exposed to a temperature between 65 and 70 degrees C., by which a great number of bacteria are destroyed. Milk brought in by dairymen showing 16,000,000 bacteria to 1 c. c., after Pasteurization shows a count of 100,000 per cu. cm. While Pasteurization might partially settle the question of clean milk it would put the small dairymen out of business and restrictions about

cleanliness would be in a great measure removed. Lactic acid and other bacteria are destroyed which are necessary for the flavor in butter and cheese. During the past year the bacterial count at the dairies has conformed to the standard of 500,000 colonies per cu. cm., most of the best dairies showing from 50,000 to 300,000. The particular disadvantages for clean milk in Southern California are the dust, the warm days and transportation from the dairy to the consumer. Dairies on the electric lines have a decided advantage over those whose milk is brought to the city in wagons. The average number of bacteria in milk delivered to the consumer in Los Angeles is between 1,000,000 and 3,000,000 to one c. c. While this may seem an enormous number of germs (48,000,000 in an ordinary glass of milk) very few of this number are pathogenic. A comparative study of the bacteriological standards of other cities is of interest:

Munich, 200,000 to 6,000,000.

Wurzburg, 222,000 to 23,000,000.

Boston, 30,000 to 4,220,000.

Middletown, Conn., 11,000 to 85,500,000.

Sewage, 100,000 to 4,000,000.

The different species of bacteria found in milk are about 200. Many of these are necessary for the production of flavors in butter, cheese and in the milk itself. Among the more important contagious diseases probably transmitted by milk, are tuberculosis, diphtheria and typhoid fever.

The most important work along dairy lines of the Los Angeles Health Department for the year is the appointment of a veterinarian, Dr. L. W. Young, whose three months of work have been productive of great good. Many diseased animals have been removed from dairy herds, suffering principally from tuberculosis and actinomycosis, and after all our main hope for the future must be in the removing of diseased animals from dairy herds.

## DEPARTMENT OF DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M.D., EDITOR.

### EDITORIAL COMMENT.

NECESSARY REQUIREMENTS FOR INTELLIGENT INFANT-FEEDING.—The imitation of nature is the fundamental principle in preparing an artificial food for babies. A rearrangement of the percentages of cow's milk to correspond to the percentages of human milk is the basis of the modern method of infant nutrition. We must remember that the simple modification of cow's milk to conform to the average human milk is, however, far from supplying a universal food for nursing babes, the variations in the individual digestive powers and the needs of different babies make this an impossibility. If we know our working formula we can combine the elements in many different proportions and we shall

find, as I have always maintained, that the babe has not yet been born for whom we cannot find a suitable milk formula. There are only three correct methods of feeding babies and these are, in the order of their relative value; first, the mother's milk; second, the milk of a suitable wet nurse; and third, modified or percentage cow's milk.

The problem of the infant-feeding without the aid of the first two mentioned above is still a most difficult one.

Our recent knowledge in the modification of the proteids has been augmented by the alteration of the relative percentages of lactalbumin and caseinogen by the use of whey.

The intelligent feeding of babies, has even yet, not been widely adopted by the



medical profession. Of course in many instances the babe is not brought to the physician until the parents have decided that something is wrong. Usually it is a lack of gain in weight which prompts the mother to seek aid. This loss of weight, or lack of gain, may be accompanied by symptoms of indigestion. In most, practically all, of these cases, we find that the cause is improper feeding.

We are sometimes more fortunate in being consulted by the more intelligent parents early, before damage has been done. These parents wish to be told how to feed the baby.

If a milk food does not agree with the baby it is because one or more of its chemical constituents have been improperly combined for this particular case. It is not the fact that the baby cannot take milk, as we are so often told, but our combinations are at fault. It is our fault, and not the baby's, and he who denies this baby a properly adjusted milk and places it on some of the proprietary infant foods, has not only not fulfilled his duty, but he has done the baby irreparable harm. Any substitutes should furnish the same constituents as woman's milk—fats, sugar, proteids, salts and water, and they should be in the same proportions as they exist in a healthy nursing woman's milk. These conditions can be met only by the use of *fresh* milk from some other animal, and cow's milk is the most generally available for this purpose. While it furnishes all the constituents required, these constituents are not identical with woman's milk, and their proportions are not suited to young infants. We who are teaching these matters all agree upon the above points. There is still, however, considerable disagreement in regard to the method of adapting cow's milk to the infant's necessities. A knowledge of the difference between cow's milk and woman's milk is the first essential, and the second is the simple method of reconciling these dif-

ferences, and making them practically alike.

Many children will do very well on the most simple modification, that is, the dilution with water and the addition of cane sugar. In fact, the world contains many healthy men and women who, as children, before the days of exact milk modification, received and thrived on this very unscientific modification. It is true, also, however, that many, very many, babes not only do not do well on this formula, but do very badly indeed.

We now know that no single formula will do, because the food would be always the same, but the child is not always the same. In many instances the proteids are extremely difficult to digest, so that an intelligent practitioner has ceased to hope for a single milk formula as a correct substitute for mother's milk. The problem is unfortunately much more difficult than this, as we must consider the different elements of food separately, and adapt their proportions to each particular child.

When difficulty in digesting milk exists it is generally one of the elements that is at fault, and not the milk as a whole, which cannot be digested. I wish to lay particular stress on this statement. In this condition we must not stop the milk entirely, or reduce the proportions of all of its elements by further dilution. The one that alone is causing the disturbance is the one to be reduced.

The method of feeding is of course complex, but it is not nearly so difficult as it appears at first, and it is such an enormous step in advance that we should all master it. This method, sometimes, called the "American method," has placed infant feeding on a scientific basis. For the fundamental work we are indebted to two Americans, Professor T. M. Rotch and Mr. G. E. Gordon. The subject must be considered under two broad divisions: First—The modifications required by healthy infants with normal digestion; and, sec-

ond, those required by infants with impaired or feeble digestion, those infants who suffer from indigestion.

The digestion of all healthy infants is much alike, and they can practically all be fed in the same way. Not so, however, are the unhealthy babes; their modifications are almost endless. We must remember that a healthy infant fed from the beginning on the proper modification will almost invariably remain a healthy infant.

The first essential in the modification of cow's milk is a knowledge of differences from woman's milk.

These are the latest and most reliable analyses:

	Woman's milk Average. Per cent.	Cow's milk Average Per cent.
Fat .....	4.00	4.00
Sugar .....	7.00	4.50
Proteids .....	1.50	3.50
Salts ..	0.20	0.75
Water .....	87.30	87.25

The essential differences are: An excess of proteids and salts; acid reaction, and the bacteria of cow's milk. Its proteids and possibly its fats are more difficult to digest.

The quantity of fat is about the same, but the healthy baby cannot digest more than from two to four per cent. of the fat of cow's milk—the lower percentage at the first week of life, and the larger at the fourth or fifth month.

Many disturbances that I am called upon to correct are due to a too high percentage of fat. This is the fault with Jersey milk, and when the practitioner endeavors to overcome constipation by increasing the fats. In Philadelphia in the hot summer months we were obliged always to materially reduce the fat. We cannot modify the fat of cow's milk except in amount. The cream of gravity and that of centrifugal action seem to be the same. Freshness in the added cream is absolutely essential; fermentative changes take place very early in fat.

While the sugar in woman's milk is

always between six and seven per cent., it varies in cow's milk. In our modification we never make it less than five per cent. or more than seven per cent. We use milk sugar instead of cane sugar, first dissolved in boiling water and filtered through absorbent cotton. It is to be clearly understood that this sugar is not added for the purpose of sweetening the milk, but to make a proper formula and to supply the necessary carbohydrates.

In parts of this western country, on the vast cattle ranges, good milk sugar cannot always be obtained; then we may use cane sugar, but in only half the amount, because it is liable to ferment in the infant's stomach. It is the proteids that give us most of the trouble, and their proper modification is most important. It is here that the great difference between woman's milk and cow's milk is most apparent. Woman's milk has more lactoalbumin than casein, but cow's milk has five times as much casein as lactoalbumin. The coagulability of unmodified cow's milk in the infant's stomach is many times more dense than mother's milk. Many methods have been suggested for the adjustment of this great difference in the two milks, but we will consider only those which have stood the test of time. First—Reduce the proportion. Second—Partially predigest by peptonizing. Third—Remove the casein by coagulation with rennet ferment. Fourth—Reduce by mechanical diluents or cereal gruels. Reducing the quantity of the proteids is all that is necessary for the vast majority of healthy infants. The two mistakes that I see most of in infant feeding are, starting the feedings with a too high proteid percentage, and second, continuing too long with too low proteids. The first error causes the child to reject the milk and to suffer from indigestion, the second causes anaemia, infantile atrophy, or marasmus, and often scurvy. Always start a young baby on low proteids and always gradually

increase as they grow older. For a young infant start the proteids at about 0.50 per cent., and increase slowly, so that at the end of a month they are one per cent., and so on each month, up to the fifth, when about two per cent. may be given. Rarely will a child under one year of age tolerate the total proteids in cow's milk. It is here that so many men tell us that the infant could not take cow's milk; they have started with the proteids too high, and so upset the little infant's stomach that it is a difficult matter to make it retain any sort of food. The inorganic salts, too, are present in excessive quantities in cow's milk. They are practically one-fifth of the total proteids, but as yet we have attempted no separate modification. We can consider that when we have properly diluted the proteids the salts also will be practically correct. The only method of reducing the proteids and the salts in cow's milk is by dilution.

This valuable working table should be constantly in mind:

	Cow's milk.	Diluted Once	Dil. 2	Dil. 3	Dil. 4	Dil. 6	Dil. 9
Proteids .....	3.50	1.75	1.16	0.87	0.70	0.50	0.35
Inorganic Salts .....	0.75	0.37	0.25	0.18	0.15	0.10	0.07

Cow's milk is always acid, woman's milk alkaline; this acidity may be overcome by using lime water or chemically pure bicarbonate of soda. It requires one ounce of lime water to neutralize twenty ounces of the modified cow's milk food. One grain of bicarbonate of soda is used to each ounce of food; we sometimes double these quantities with good effect.

Cow's milk always contains bacteria, and hence should always be Pasteurized, and never sterilized.

With this short consideration of the ends that are to be accomplished by intelligent infant-feeding, we come to the very important matter of the means to accomplish this end.

Here in the far West we are unfortunate in not possessing milk labora-

tories. An excellent field exists right here to do this very necessary work, and the popularity of these laboratories is shown by their prosperous existence in sixteen of the larger cities. With a properly-equipped milk laboratory the feeding of infants with the proper formulas becomes as simple a matter as sending the proper prescription to the apothecary for the compounding of remedial formulas.

In ordering from these laboratories we simply write for the percentage of fat, sugar and proteids which it is desired to give the baby. The number of feedings in twenty-four hours and the quantity of each feeding are indicated. For example, a typical prescription of this kind would read thus, indicating that we desire a modification in the fat, proteids and salts:

R

Baby Smith, aet. four months.

Fat .....	3%
Sugar .....	4%
Proteids .....	1%

Alkalinity, Lime Water .....5%  
 Number of feedings .....8  
 Amount at each feeding.....4 ounces  
 Heat to 155 degrees F., twenty to thirty minutes.

Or we may have printed such a blank as this:

R

PER CENT.

Fat .....	
Milk Sugar .....	
Proteids .....	
Salts .....	
Water .....	
Date .....	190.....

REMARKS.

No. of feedings .....  
 Amt. at each feeding .....  
 Alkalinity .....  
 Heat at .....° F.  
 Infant's age .....  
 Infant's weight .....  
 Signature .....



Holt has recently said that those whose knowledge of laboratory feeding consists only in the acquisition of a few formulas, which are supposed to be proper for the early, middle or late period of infancy, are in little better position than one who feeds all children under his care on Dr. A.'s or Dr. B.'s "mixture," or upon any other commercial infant foods. The result will probably be about the same.

An equally improper way of using the laboratory is that of those physicians who know nothing of milk percentages, and care less, and who simply write, as I have known many of them to do, such directions as the following: "Send milk suitable for a three-months-old baby."

There are many advantages in laboratory feeding; we can accurately vary the different constituents to a fraction of a per cent., and we are sure that we are getting what we have ordered. We are independent of stupid nurses and nervous mothers.

Objection to laboratory feeding has mainly crystallized under three heads:

First—Expense, which is forty to sixty cents a day.

Second—A subtle change in the fat by its centrifugal separation, which impairs its nutritive values and renders it hard to digest.

Third—It cannot be used without the advice and guidance of a physician.

The first of these is indeed an objection, and is prohibitory in many instances. The second I do not believe to be a fact, and the third is no objection at all, as the disastrous results that we see are due to an endeavor to feed the baby by the advice of friends or the circulars of the manufacturers of commercial infant foods.

The proper artificial feeding of a baby by any of the accepted methods requires the attention of a physician who understand milk modification, for the first few weeks of the feeding, or perhaps longer if a healthy individual is to be assured.

If the physician does not understand modified milk feeding, his efforts will prove failures under all circumstances.

Those of us who use this method alone place it in value next to maternal feeding.

In my *Cyclopedia of the Diseases of Children*, Rotch has contributed his masterly articles on percentage feeding, both in the editions of 1889, 1899 and 1901.

The following schedule is about what has been agreed upon in accordance with his suggestions, for the average healthy infant. It shows the percentages of fat, sugar, proteids and quantities, and is published in all the text-books.

The percentages of Fat, Sugar and Proteids and the Quantities for the Average Healthy Infant are:

AGE	Percentage of Fat	Percentage of Sugar	Percentage of Proteids	Quantity for one feeding Ounces	Quantity for one feeding Grammes	Number of feedings in 24 hrs.	Interval by day.
Premature infants ...	1.00	4.00	0.25	$\frac{1}{4}$ - $\frac{3}{4}$	7-22	12-18	1-1½ times
First to fourth day..	1.00	5.00	0.30	1-1½	30-45	6-10	2-4 "
Fifth to seventh day.	1.50	5.00	0.50	1-2	30-60	10	2 "
Second week .....	2.00	6.00	0.60	2-2½	60-75	10	2 "
Third week .....	2.50	6.00	0.80	2-3½	60-110	10	2 "
Fourth to eighth week	3.00	6.00	1.00	2½-4	75-125	9	2½ "
Third month .....	3.00	6.00	1.25	3-5	90-155	8	2½ "
Fourth month .....	3.50	7.00	1.50	3½-5½	110-170	7	3 "
Fifth month .....	3.50	7.00	1.75	4-6	125-185	7	3 "
Sixth to tenth month.	4.00	7.00	2.00	5-8	155-250	6	3 "
Eleventh month .....	4.00	5.00	2.50	6-9	185-280	5	4 "
Twelfth month .....	4.00	5.00	3.00	7-9	220-280	5	4 "
Thirteenth month ...	4.00	4.50	3.50	7-10	220-310	5	4 "

The home modification of milk will be the only resource for the majority of physicians living outside of the sixteen large cities in which milk laboratories have been established. Of course no plan of home modification yet suggested is as accurate as a laboratory feeding, but if the directions are carefully and intelligently carried out the method is practical and of extreme usefulness, many of us think quite as useful as laboratory feeding. The method must be simple enough to be readily grasped by the mother or nurse.

All the methods require a little study, and the directions must always be in writing.

The physician must have a knowledge at least, of the approximate formula of the milk and cream used in each particular case.

We must remember to start very young babies on a low proteid and low fat formula. We shall find by experience that we may classify our feedings under three grand headings as suggested by Holt, some years ago. 1. The formula in which the fat is three times the proteids. 2. Those in which the fat is twice the proteids. 3. Those in which they are equal or nearly so.

milk—that is, 1.50 per cent.—until the child is four months old.

The correct method of procedure in feeding a young baby is to secure a milk combination containing three times as much fat as proteids and then dilute with boiled water to which 5 per cent. milk sugar has been added, until the food is appropriate to the child's age and digestion. This may be readily done in a home by taking the upper third of a quart jar of milk which has stood about eight hours, which will give us ten-per-cent. milk, that is, a milk containing 10 per cent. of fat, 3.3 per cent proteids and 4.3 per cent sugar.

If the family is not so situated that they can obtain the milk in sealed glass jars we can make the same formula by taking equal parts of plain milk and the ordinary cream. Gravity cream derived from the top of average milk that has stood eight hours or more is 16 per cent cream. This is what we mean by ordinary cream. Of course it is necessary to know how the mother obtained the cream in order to have an approximate knowledge of its fat percentage. For this purpose the following working table is appended. It is the one accepted by all of us who use percentage feeding.

Removed from 1 quart glass jar.	Hours milk has stood.	Approximate fat per cent.
Upper 1-2.....	.8 or more.	7 per cent
Upper 1-3.....	.8 or more.	10 per cent
Upper 1-4.....	.6 or more	16 per cent
Upper 1-4.....	.8 or more.	12 per cent
Upper 6 ounces.....	.8 or more.	16 per cent
Upper 4 ounces.....	.8 or more.	20 per cent

The first formula will be appropriate to the first period of infancy (from birth to four months). The second to the middle period (from three or four to nine or ten months), and the third to the later period (from ten or twelve to fourteen or sixteen months).

In feeding modified cow's milk we do not reach the proteid content of woman's

Whole milk is approximately 4 per cent cream.

Percentage feeding of course requires some little mathematical knowledge and some use of one's memory, but it is not at all difficult if the matter is stripped of all superfluous and complicating verbiage and is stated in a clear

and concise manner devoid of all attempts to assume superior knowledge.

The whole keystone of our modification depends on the well-known fact that when milk is obtained from a dairy in a reasonable time after milking, it will separate by gravity into top milk, or cream, and skim milk, and most important of all, this separation will take place in certain definite proportions.

The credit of calling our attention to this is due first to Meigs of Philadelphia, then to Biedert of Paris and Chapin of New York. All of these careful observers showed that it is possible to construct from top milk definite percentage mixtures.

Top milk has an average definite fat, sugar and proteid content and Meigs of Philadelphia was the first to give us a practical working percentage mixture from top milk. Since then, of course, his original and painstaking work has been much amplified, but his principles are as true now as they were then.

In the modification of milk we have five elements to deal with—top milk or cream, proteids, diluents, milk sugar and lime water.

Let us for a moment consider these seriatim before proceeding to our account of the methods of actual modification.

Top milk has been considered already in the table last given; its percentages may be considered nearly accurate. The proteids in top milk are constant and may be considered to be present in the proportion of 3 to 1 (3 of fat to one of proteid) in ten or twelve per cent. top milk.

The diluent is usually boiled water, but barley gruel or whey is often used. Their function is to dilute and modify the caseinogen and the fat. Milk sugar should be chemically pure and is dissolved in the boiled water in the strength of five or six per cent. If barley water is used the milk sugar is to

be dissolved in it while it is boiling, else a residue will occur.

Lime water is to be added to all milk percentage formulas in the proportion of one-twentieth to one-twenty-fifth of its bulk. Then this is our problem in feeding babies: To so combine the ingredients of cow's milk that the baby can digest, grow and thrive—and all babies should be fed either on mother's milk or modified cow's milk.

Let us see then how it is most convenient to work out all this knowledge in a practical every-day way.

We can make our calculations by using either the fats or the proteids as the unit. In top milk the first nine or ten ounces will have a fat proteid ratio of three to one. That is, the proteids will be one-third the fat, or conversely the fat will be three times the proteids.

We thus decide what percentage of one or the other ingredient we will give the baby, and the fat and proteid will exist in the formula in the ratio indicated above.

We will take a well-known example that is given in the text-book: That is, an infant at birth should have 0.5 per cent. of proteids and 1.5 per cent. of fat.

We will use the 12 per cent top milk as per table above (that is the upper 1-4 of a quart jar of milk that has stood 8 hours). The total amount to be given in twenty-four hours is 8 ounces. Now our milk contains 12 per cent. of fat, but we wish to give only 1.5 per cent. Therefore our problem is how much of this 12 per cent milk are we to use to make a 1-5 per cent, 8 ounce mixture for the baby? Mathematically it is expressed thus: If of a 12 per cent top milk we use 8 ounces in twenty-four hours, to make a 1 per cent top milk we would use 1-12 of 8, or 2-3 ounces.

To make a 1.5 per cent top milk you would use 1.5 times 2-3, or 1 ounce. Therefore 1 ounce of our 12 per cent. top



milk added to 7 ounces of boiled water will give us a 1.5 per cent. mixture.

Let us suppose that a one-month-old baby is brought to us to place on a

healthy baby is to know the number of feedings, the amount at each feeding the percentage of the top milk and the percentage that you wish to use.

$$\text{The formula thus becomes: } \frac{\text{Desired percentage}}{\text{Known percentage}} \times \text{total quantity} =$$

proper milk diet. We will proceed thus: An infant at that age must start with low proteids. We will prescribe a 1 per cent proteid, 3 per cent fat and 5 per cent sugar as formula. These babies need ten feedings in twenty-four hours. Each feeding contains 2 1-2 ounces, or a total of 25 ounces.

We will use the same milk, that is, 12 per cent top milk. To get 3 per cent fat we will require 3.12 of 25, or 6 1-4 ounces of 12 per cent top milk and 18 3-4 ounces of boiled water. This boiled water is to contain 6 per cent of milk sugar prepared as detailed above. This is about 7 teaspoonfuls.

Let us take a further illustration:

The baby, we will suppose, is four months old. We will have to take the sixteen ounces of top milk, that is, the half of a quart jar that has stood eight hours. This will give us 7 per cent. fat. The ratio of proteids here will be as 2 is to 1.

The age formula is 3 per cent fat 1.5 per cent proteids and 5 per cent sugar; eight feedings in twenty-four hours, each feeding 5 ounces. A total of 40 ounces in twenty-four hours.

We desire but 3 per cent fat and the milk that we are using contains 7 per cent. fat. The total food is 40 ounces, therefore we require 3.7 of 40, or 17 ounces of top milk in 23 ounces of boiled water containing 9 teaspoonfuls (or 6 per cent) of milk sugar (In feeding such an amount as this we use two quart bottles of milk, take the top half of each and mix together, and the result, 32 ounces, use 17 ounces.)

As you will observe, all that is necessary to adjust a milk formula for a

amount of top milk to be used (with sufficient diluent to bring mixture up to the required total quantity).

The only feat of memory that is required in the proper feeding of babies is to know what amount to give, how often to give it, and what the percentage of fat and proteids should be. This, disabused of all the complexity which has surrounded it, is a very simple matter, indeed, and can readily be kept at one's finger tips.

## REVIEW OF THE LITERATURE.

THE RELATION OF THE APPENDIX TO PELVIC DISEASE.—Peterson has made an interesting study of this relation in women, and he records his conclusions in the *American Journal of Obstetrics*:

"1. In the first series 50 per cent. of the specimens were microscopically normal. In the second series 49.3 per cent. were also normal.

"2. In the remaining 50 per cent. there was evidence of present or past acute or chronic inflammation.

"3. The average length of the appendix was eight to ten centimeters.

"4. It was adherent in 18 per cent. of the first series and 23.4 of the second.

"5. Appendices may be club-shaped, constricted, or bent, and still be perfectly normal.

"6. There were faecal concretions in 8 per cent. in the first series, and 16.4 in the second. The concretion did not always denote disease.

"7. In seventeen cases, with chronic disease of the appendages, there was also disease of the appendix.

"8. In some of the cases of chronic disease of the appendages the appendix, though adherent, was normal in other respects.

"9. About half the cases in which there were uterine fibromata there was evidence of present or past disease of the appendix.

"10. Of eight cases of ovarian cyst, nine were accompanied by disease of the appendix."

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WHEN NOT TO OPERATE FOR APPENDICITIS—J. E. Moore, Minneapolis (*Journal A. M. A.*), combats the dictum that all cases of appendicitis are operative cases, and holds that while certain classes of cases, such as chronic appendicitis, without acute attacks, those with localized abscesses, and acute cases seen in the beginning of the attack, call for operation provided hospital facilities and a good surgeon are available, there are others, he believes, in which surgical interference is not advisable. The conditions in which the radical operation is not the best treatment are summarized by him as follows: "First, when the patient is evidently moribund; second, when the patient is evidently convalescing; third, when certain grave complications are present; fourth, in the mid-way cases, beginning with the third day when the physician and surgeon are in doubt; fifth, in the extreme cases of suppurating peritonitis." Even in serious complications or when general anesthesia is contradicted by the condition of the patient, if localized abscess exists, he states that it should be evacuated under local anesthesia. Ochsner's starvation treatment, Moore says, has been badly misunderstood. Ochsner did not recommend starvation and lavage for appendicitis, but for spreading peritonitis due to neglected appendicitis. In such cases, Moore, by opening abscesses locally, and by using to a greater or less extent Ochsner's method, has been able to tide them over to a successful interval operation.

\* \* \*

THE PROTECTIVE FUNCTION OF THE OMENTUM.—E. de Renzi and G. Boeri

draw the following conclusions from their researches:

Removal of the omentum determines in young animals an inferior condition, a retardation of development; it produces in the adult animal a diminution of resistance to action of poisons introduced into the peritoneum, and a greater susceptibility to infection contracted by means of the peritoneum. This organ also possesses a great plasticity, which is utilized by surgeons every day.

The omentum reabsorbs all foreign corpuscles introduced into the peritoneum, extravasated blood, for example. It has, besides, a physiological function; it dissolves the blood, it acts as an adjunct to the spleen, taking the place of that organ after splenectomy.

Cutting off the blood supply of the spleen by ligating the vessels results in the complete absorption of that organ by the omentum.

Simultaneous removal of the spleen and the omentum does not cause the death of the animal.

Removal of the omentum and simultaneous ligation of the splenic blood vessels causes death of the animal by rapid reabsorption of the toxic products resulting from autolysis of the necrotic spleen.

Mascarini has, however, been able to make this last experiment without causing the death of the animal. In this case the usual defensive plastic and phagocytic action of the omentum was undertaken by the neighboring peritoneum acting as a sort of supplementary and compensating organ.—*Nuova Rivista Clinica Terapeutica*.

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EMERGENCY LIGATURE.—Any kind of strong thread boiled in 5 per cent. carbolic solution for 20 minutes, or in plain water for half an hour makes a good sterile suture material in an emergency.—*Carolina Medical Journal*.

\* \* \*

TREATMENT OF MUMPS.—G. Carriere (*Le Nord Med.*), says that mumps is an

Infectious disease, epidemic and contagious, and that it should be treated accordingly, instead of being ignored, as is done at present. The infection enters by the mouth or naso-pharynx, invades the parotid gland, by way of Steno's duct, and then enters the circulation. The contagion begins at once, and the child should be at once isolated. In schools the child should be at once excluded. At the end of two weeks the contagion is no longer to be feared. Isolation should be complete. Everything used by the patient should be carefully disinfected, the room also after the patient has recovered. The patient should be in bed, and should not go out until eight or ten days after the end of the fever. Nephritis has been observed after mumps. The nasal cavity, mouth and pharynx should be disinfected daily, and the parotid should be treated by internal medication with quinine and salicylate of soda, as well as by medicines that are eliminated by the saliva, such as mercury, iodides and bromides. The complications are otalgia, orchitis and oöphoritis, and all should receive appropriate treatment. The last two require rest in bed and tepid baths and applications.

#### BOOK REVIEWS.

THE HEALTH CARE OF THE BABY. A Handbook for Mothers and Nurses. By Louis Fischer, M.D., Attending Physician to the Wilbur Parker and Riverside Hospitals; former Instructor in Diseases of Children in the New York Post Graduate Medical School, etc. 12 mo. Cloth, 75 cents. Funk & Wagnalls Co., N. Y.

This little book of one hundred and forty-four pages is the production of the well-known pediatric writer, Louis Fischer, who has won a place for himself by his *"Infant Feeding in Health and Disease,"* and by his text-book on *"Diseases of Infancy and Childhood."*

The little brochure that we are considering is divided into three general parts, and contains suggestions and advice for infant feeding in health and disease, and when the stomach and bowels are out of order. It also gives directions for the

management of fever, and is a guide during such diseases as measles, croup and skin diseases. In cases of accidents, poisoning, and the like it gives ample advice to follow until the physician arrives. The correction of bad habits and the management of rashes have received careful attention.

There is much to commend in this mother's guide, and it is a safe book to recommend to them, and to nurses who are engaged in the care of babies.

The proprietary foods receive the condemnation which they deserve, for infants under six months of age. The laity are not competent to feed an infant by following directions on the label of a box of food. No infant food will agree with and be properly assimilated and digested by every baby. Individualization is absolutely essential in infant feeding, the digestive functions are totally different in different babies, and only after the infant's wants have been carefully studied can we prescribe the kind of food, the amount of food, and the feeding interval demanded. Because an infant gains in weight it is not proof positive that he is in good health. When a large amount of starch, as dextrinized starch and large quantities of sugar, are given to an infant, there is usually a notable increase in weight. Bone and muscle, which are formed chiefly by the proteid element of food, cannot be replaced by the carbohydrates or fat-forming foods. To satisfy the ambition of many mothers to display a big fat baby, proprietary foods have frequently been added, in very large amounts, thus overtaxing the digestive apparatus and ending in dyspepsia or enlarged stomach.

A short time ago a physician would have been in doubt if requested to name a book for a mother to read in regard to the care of her family. The work here before us is one about which a physician could have no doubt. It is just the work to give to a mother or a prospective mother. We most heartily commend it.

W. A. E.



## DEPARTMENTAL

## DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTENGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

MEDICATION IN TUBERCULOSIS.—Walsh, in an article in the *Georgia Practitioner*, June, 1905, deals with some of the most important conditions which we have to meet in treating tuberculosis.

Unfortunately the tuberculosis patient is often told that medicine cannot help him. This statement often gives the patient the idea that it is useless to consult physicians for this malady. Now if there is ever a disease which needs the careful supervision of an intelligent physician it is tuberculosis, and whether or not we treat this disease with drugs, nevertheless the skill and intelligence acquired by a thorough study of medicine should offer these patients great hope. Instead of saying that medicine can do nothing for tuberculosis, I would say that the knowledge that has been derived from the careful study of this disease during the past few years, offers every hope to the tuberculosis patient. The let-alone policy or the half-hearted policy which is usually carried out does mean very little to him. If physicians, however, will follow out the most recent teachings of those who are making this a careful study they will be able to prove to their patients that medicine can do very much for them. Rest, fresh air and good nourishment will do very much for the tuberculous patient, but they will not do as much as can be done if other measures are added.

Walsh calls attention to the remedies which are of value in treating these various complications. The principal complications are hemorrhages, colds and mixed infection.

In regard to hemorrhage, the method

of treatment which is commonly used is absolutely faulty. Perhaps there is no drug which is used more than morphine in hemorrhage, and if it is used properly, it is a very good one; but the routine use of morphine in hemorrhage is absolutely wrong. A great many cases of hemorrhage will get along better without morphine than with it, unless the patient be extremely nervous.

In the treating of arterial hemorrhage there are certain objects to be obtained. The first is the formation of a clot at the point of rupture of the vessel which nature nearly always fulfills. The second is to retain that clot in position until organization can take place. Anything then that will tend to force this clot out should be avoided. The indications then are to keep blood pressure low and prevent unnecessary movements and straining on the part of the patient. Walsh deals with the subject of hemorrhage as follows:

"For the treatment of a hemorrhage it is necessary to consider the cause. Hemorrhage may occur first from a ruptured blood-vessel in the floor of an ulcer or cavity. These hemorrhages are comparatively rare and occur almost only in very advanced cases.

"Secondly, hemorrhages may occur as a result of high arterial tension. This is evidenced by sharp accentuation of the second sound, either at the aortic or pulmonary valves or at both. Third, hemorrhages may occur from an area of congestion. In these cases the signs of acute inflammation are found in the neighborhood of the lesion or even throughout the lung. These signs are coarse, moist rales or crackling or sub-

crepitant rales with more or less consolidation. In all of the three cases the primary hemorrhage may be quite large, may even be repeated, and the patient may expectorate blood for some days subsequently.

"In case of hemorrhage from a ruptured blood vessel there is absolutely nothing to do but put the patient at complete rest, administering, if necessary to accomplish this, a hypodermic injection of morphia. If the ruptured vessel is of large calibre there is nothing we can administer internally that will act with sufficient power to close it; if of small calibre, the rest will do all that can be done.

"Hemorrhage from the second cause, namely, high arterial tension, practically always responds to small doses of nitroglycerine (gr. 1.100) administered every three to six hours, or even less frequently, depending on the tension. When the accentuation is very marked, and the pulse bounding, it may be given every three hours until the accentuation lessens, and then less frequently; if the accentuation is slight and the hemorrhage small (a dram or two at a time), three times a day over a period of ten days or two weeks is usually sufficient. In my experience, these hemorrhages are most frequently the result of a strain, like, for instance, a long walk, a steep climb, a heavy lift, overwork, etc.

"Hemorrhage from the third cause, namely, local or general congestion, is probably the most common. The typical experience presented to the consultant in these cases is a patient in the throes of an acute cold, manifesting itself by a feeling of constriction across the chest, an inflamed throat and signs of general acute bronchitis. The bowels, constipated on account of the fever, have been blocked up entirely by morphia or astringents given for the hemorrhage. The activity of the kidneys is diminished. The arterial tension raised

usually by the toxine of the cold is increased by the toxæmia resulting from retention of excretions. The indications, therefore, are plain; open the bowels freely by repeated doses of Epsom salts and keep them open until the patient stops expectorating blood. Open the peripheral circulation by small doses of nitroglycerine (gr. 1.100) administered every three to six hours.

"If scattered moist rales are present, instead of sedative cough mixtures, which tend to check the bronchial secretions, stimulating cough mixtures are indicated, like, for instance, ammonium chloride, ammonium carbonate, aromatic spirits of ammonia, etc. I have seen numerous hemorrhages continued for ten days to several weeks stop promptly in two or three days on this treatment. I have personally never seen benefit from extract from suprarenal, adrenalin, chloride, gallic acid, tannic acid, aromatic sulphuric acid or the other things commonly recommended in hemorrhages.

"Very rarely, in place of an accentuated second sound or a cold, we find the hemorrhage apparently due to relaxation of the arterial system. This is indicated by a low tension pulse and the exclusion of other causes. In this case tincture of digitalis will stop the hemorrhage. These cases are, however, extremely rare, and are hence the least to be considered.

"In any hemorrhage, rest in bed is advisable. If, however, there is only an occasional spitting of a small amount of blood-streaked sputum, it may not be necessary to put the patient in bed, though even in this case rest is called for.

"To resume, the most commonly useful remedies in hemorrhage are nitroglycerine and Epsom salts, the most frequently harmful are opium and its derivatives, and astringents.

"Nitroglycerine has also been recommended in the lumbar pains so common

in connection with tuberculosis of the lungs. It is very possible that these pains are due either to a toxic nephritis or an actual development of tubercles in the kidneys."

\* \* \*

COCILLANA AS AN EXPECTORANT IN PULMONARY TUBERCULOSIS.—Norris, in the *Therapeutic Gazette* for June, 1906, records his experience with the use of Cocillana as an expectorant in pulmonary tuberculosis.

While expectorants have fallen very much into disuse in the treatment of this disease, yet there are times when it seems that such a remedy can be of value if we could find one that would do the work without doing any serious harm. Cocillana, as Norris says, is made of the bark of *Sycocarpus Rusbyi* (natural order *Meliaceae*), a large tree found in Bolivia. The physiological action is said to resemble *ipecacuanha*. As an expectorant it is supposed to have a more stimulating effect than the latter drug, and also to act as a mild laxative and a cardiac tonic. The bark in doses of from twenty to fifty grains causes vomiting, accompanied by prostration and purging, sneezing, frontal headache and nasal discharge. \* The fluid extract is the preparation which Norris used, and the dose ranges from five to twenty-five drops, which may be administered every three or four hours.

His experience was based on thirty-one tuberculous patients. Of these, six were in the early, twelve in the second, and thirteen in the far advanced stages of the disease. He obtained the most satisfactory results by administering it in five-drop doses, well diluted with water, at three-hour intervals.

In every case especial records were kept as to the amount of cough; the amount of expectoration; and the effect upon the gastro-intestinal and cardiac systems.

The results of the administration in

these cases were marked improvement in seven cases; slight improvement in fourteen; no improvement in eight; apparently worse in two.

Norris says: "On the whole the results were not as satisfactory as those obtained by the administration of the following mixture, which is largely used in the dispensary and wards of the Phipps Institute when this character of medication is resorted to:

R

Ammonii chloridi ʒiv

Spiritus glonoini, min. i.

Spiritus ammoniae aromatici, fʒi.

Tr. nucis vomicae, tʒss.

Elixiris calisayae q. s. ad. fʒvi

M. Sig.: Dose, one teaspoonful in water.

It will be seen that the foregoing is composed mainly of remedies calculated to sustain the heart, and relieve pulmonary congestion by dilation of the systemic arteries. This mixture, while extremely unpalatable, clinically is productive of excellent results."

GERSUNY ASCRIBES TO MECHANICAL INJURY of the bladder wall a certain proportion of the cases of cystitis that develop after repeated catheterization. In order to prevent this he uses a short-curved glass catheter with a projecting shoulder, which prevents its entering beyond a safe distance. In thirty-five cases in which this catheter was used after operation, cystitis developed in only one instance, although slight urethritis was observed in four cases. The patient with cystitis had required catheterization thirteen times and others four or five.

LIME IN THE EYE.—A solution of sugar in vinegar is recommended as the quickest relief for lime in the eye. The sugar forms an insoluble compound with the lime. A few drops should be introduced, and the eye washed with plenty of water.



# SOUTHERN CALIFORNIA PRACTITIONER.

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

Address all communications and Manuscripts to

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## EDITORIAL.

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### CATS.

In a recent number, the *Medical Record* says editorially:

"The sanitarian has cogent grounds for discouraging the perpetuation of the cat as a household pet, and it would be the part of wisdom for the family practitioner, even at the risk of falling in the estimation of the youthful members of his clientele, to utter a serious word of warning anent the the very real possibility of disease transmission through the house cat. The enumeration of scarlatina, influenza, whooping-cough, measles, diphtheria and ringworm probably not exhaust the list of diseases whose communication has been or might be ascribed to this intermediary. Even the proudest and sleekest tabby yields readily to atavistic calls; and prowls in unseemly places, refections in strange garbage cans, and midnight conclaves with the mangy outcasts of the gutter

afford ready opportunities for the acquisition of contagious materials. Practically all cats have worms, most of them suffer from catarrhal conditions of the nasal passages, and the feline method of ablution is not such a to command the respect of the hygienically inclined; while no one who has witnessed the enthusiasm with which children caress their pets can fail to realize the magnificent opportunities for infection that are afforded in this way. Cats and fleas are nearly always associated, and the importance of suctorial insects as inoculating agents has been so much emphasized of late that the possibility of danger in this direction also is not altogether remote. At any rate, it appears that the doctor, like the dog—that other friend of man—must in the interest of public health set his face against the fireside sphynx and warn parents against its possibilities for harm. He should at

least see to it that no cat is allowed to enter a sick room."

### **BISHOP CONATY'S ADDRESS ON SCIENCE, RELIGION AND THE PHYSICIAN.**

It is generally conceded that the Right Reverend Thomas J. Conaty, Bishop of Monterey and Los Angeles, in addition to his many other eminent attainments, is not only one of the most popular but likewise one of the most polished, forcible and entertaining orators and after-dinner speakers in California.

Large and broad in physique, so is he also in his mental and spiritual make-up, and we are glad, not only that the recent commencement exercises of the College of Medicine of the University of Southern California were graced and honored by having Bishop Conaty deliver the address of the evening, but that the PRACTITIONER is able in this issue to present to its readers and preserve in permanent form a line of thought which will benefit us all to read and take to heart.

### **THE LOS ANGELES COUNTY MEDICAL ASSOCIATION CLOSES A SUCCESSFUL YEAR.**

On June 29th the Los Angeles County Medical Association held its last meeting prior to the usual summer vacation of three months. This fact is worthy of note, because the six months just closed have demonstrated that the medical profession of Los Angeles is strong enough to sustain weekly scientific meetings, with no deterioration in the quality of papers or any diminution in the attendance.

The credit of this innovation of weekly meetings—an innovation, by the way, in which Los Angeles leads all other county

medical associations in the Golden State—belongs not only to the present officers, but also to the preceding administrations during which the Los Angeles County Medical Association was steadily moving forward to take the position it now occupies, as the official exponent of the views of the medical profession of Los Angeles and as its recognized center of scientific work.

By the time the fall term of the Association begins, the doors of the new Barlow Library will probably have been opened, and with this additional impetus to high-grade scientific work and development, the members of the County Medical Association may look forward to receiving increased profit from their meetings.

The advance made by the Los Angeles County Medical Association during the year 1906 has been notable. With an excellent reference library at hand and the addition of the social features to the meetings the Society in a few years should be able to consider a club-house and meeting place of its own, where the good fellowship and scientific progress so necessary to the development of a strong *esprit-de-corps* may work uninterruptedly for the good of the profession in this portion of the State.

### **A NEW METHOD OF READING PAPERS AT MEDICAL MEETINGS.**

The Ophthalmological Section of the American Medical Association, at its recent Boston meeting, instituted a new method of carrying out its scientific program, which will no doubt be much copied, once its benefits become generally known. The plan has for its ob-

ject a full and scientific discussion of the papers read before the Section.

It is well known how persons called upon to take part in the discussion of a paper use their time only too often in a long-winded dissertation that is but remotely connected with the essayist's topic. This, however, is not to be wondered at, for it is hardly fair to expect a man to discuss off-hand, scientifically and critically, a subject to which the essayist may have been giving months of thought, but to which the speaker may have given but little attention.

Moreover, it should be recognized also, that few medical men have had the preliminary training that will enable them to clearly, logically and entertainingly present their opinions in speech when called upon, without warning, to discuss an essay.

The Ophthalmological Section, recognizing these facts, and in order to make its meetings take on a higher scientific tone, this last year sent out advance printed copies of the papers to be read, to all members of the Section. The essayists were allowed to present only the shortest digests of their papers and the subjects were then declared open to discussion both by the members regularly assigned for parts in the discussion and by others also.

What was the consequence of this method? If we are to believe the testimony of those who were in attendance at the meetings, the Ophthalmological Section never had a more successful session.

Now that the value of this plan has been demonstrated it will probably be taken up by other sections also and per-

haps in time, by the State and County Medical Associations.

That the value of any paper can be greatly enhanced by a good discussion is agreed to by all. To bring out a good discussion the members who speak upon the subject must be familiar with the points in the papers, and by approaching the facts from different view points be able to bring out other phases. And because the method just explained promotes this thorough, critical and scientific discussion and consideration of the subject matter of a paper, it will no doubt, be widely adopted.

#### THE MILK SUPPLY OF LOS ANGELES.

The summer time is here, and with its coming we may expect the usual large increase of morbidity and mortality from diseases of the gastro-intestinal tract, especially among children. The reason for this annual loss of life among infants is well known. In the great majority of cases it can be traced to an impure milk supply.

The PRACTITIONER presents in this issue several articles on this pertinent topic: one by Dr. Joseph Roby of Rochester, New York, on "*The Economy of Producing and Marketing Certified Milk*;" a second, by Dr. E. L. Leonard, City Bacteriologist of Los Angeles, on "*The Milk Supply of Los Angeles*;" and a third, by our department editor, Dr. William A. Edwards, who presents in his column a consideration of "*The Necessary Requirements for Intelligent Infant Feeding*."

These are valuable and interesting articles, and the PRACTITIONER takes pleasure in presenting them to its readers.



**THE BOSTON MEETING OF THE AMERICAN MEDICAL ASSOCIATION.**

Returning members of the recent American Medical Association meeting at Boston, as well as the accounts in the medical press, alike bear testimony that this Boston meeting was the most successful, both from the scientific and social standpoints, that the A.M.A. has ever held.

The new mode of organization of the A.M.A., under which so much good has already been accomplished, thus receives an additional tribute to its practicability and desirability. The 1907 meeting will be held at Atlantic City, and will, even though some of the evidences of Boston culture be missing, be no doubt a most successful session.

Incidentally it is creditable to the Los Angeles County Medical Association that so large a number of its members put their work aside in order to be in

attendance at the meeting of the national organization.

**THE CALIFORNIA STATE BOARD MEDICAL EXAMINATIONS IN LOS ANGELES IN AUGUST.**

The President of the California State Board of Medical Examiners, Dr. John C. King of Banning, has requested the PRACTITIONER to announce an August examination in Los Angeles. His letter follows:

BANNING, Cal., June 20, 1906.

*Dear Doctor:* Please announce a California State Medical Board examination in Los Angeles for Tuesday, Wednesday and Thursday, August 21st, 22nd and 23d. All applications and credentials should be filed with the secretary, Dr. Chas. L. Tisdale, Alameda, Cal., prior to August 1st. No applications received after August 5th will be considered, and any filed after August 1st must be in perfect form.

Yours,

JOHN C. KING.

**EDITORIAL NOTES.**

Dr. E. R. Bradley, a well-known Los Angeles physician, is traveling in Alaska.

Dr. Ida B. Parker, health officer of Orange, Cal., has resigned.

Dr. Watson, late of Seattle, has located in Long Beach, Cal.

Dr. W. C. Chisholm of San Francisco has located in Goldfield, Nev.

Dr. P. J. Parker of San Diego is now in New York City.

Dr. W. E. Stewart of Los Angeles has located in Anaheim.

Dr. H. E. Stroud of Phoenix is about to locate in Los Angeles.

Dr. A. Tyroler of Los Angeles is doing post-graduate work in the East.

Dr. W. H. Flint of Santa Barbara was

recently called professionally to Los Angeles.

Dr. J. A. McGarry of Los Angeles has recently returned from a trip to the Yosemite.

Dr. S. V. Fitzsimmons recently drove from Prescott, Ariz., to Globe, Ariz., in five days.

Dr. J. J. Fleming of Wickenburg, Ariz., has been elected treasurer of the Hassayampa Sanatorium.

Dr. W. P. Sipe of Flagstaff Ariz., has recently had an interesting trip through the Grand Canyon.

Miss Adele Dohany, a trained nurse of Los Angeles, is superintendent of nurses in the new hospital at Whittier.

Dr. Sarah Maloy of Riverside is putting in two months in post-graduate work in Chicago.

Dr. Z. T. Martin of Roswell, New Mexico, recently made a trip to the East.

Dr. E. Pane Palmer of Phoenix, Ariz., is traveling in Alaska, and will return home by way of Yellowstone Park.

Dr. J. H. Wroth of Douglas, Ariz., is spending a few weeks in the pine woods of northern Maine.

Dr. A. M. Tuthill of Morenci, Ariz., was recently called professionally to Phoenix.

It is said that the German cities present good openings for graduates of American dental schools.

Dr. O. P. Paulding has been appointed health officer in Santa Maria, Santa Barbara county, Cal.

Dr. J. R. Liverman of San Bernardino, Cal., has been quite ill, but is now comparatively well.

Dr. C. W. Lawton, until recently resident physician in the California Hospital, has located in Long Beach and become associated with Dr. J. W. Wood.

Dr. A. F. Wagner, formerly of Alhambra, Cal., has located in Downey and formed a medical partnership with Dr. J. W. Rowley.

Dr. W. I. Simpson of Phoenix is doing post-graduate work in Chicago, and in September he will return to Phoenix and enter the office of Dr. Ancil Martin.

Dr. Mary L. Neff of Phoenix, Ariz., was recently a visitor in Los Angeles. While here she put in her time very devotedly at the hospitals.

Dr. James Taylor Sheldon died June 8th in Tustin, Orange county, Cal., at the age of seventy-eight. He was a graduate of Rush Medical College.

Drs. J. M. Dunsmoor and R. F. Clark are candidates for coroner of Los An-

geles county. The present incumbent, Dr. John H. Trout, is also in the field.

Dr. Wm. H. Flint, the prominent Santa Barbara physician, has gone to his old home, Richfield, Conn., to spend his vacation.

Dr. A. F. Maisch, of Globe, Arizona, has just spent over five months in the hospitals of New York City and is now again attending to his practice in Globe.

The Associated Charities of Pasadena have bought a piece of land upon which they are going to locate a permanent tuberculosis camp.

Dr. Stanley P. Black, Professor of Pathology in the College of Medicine of the University of Southern California, has been traveling in the East.

Dr. W. E. Day, city health officer of Prescott, Ariz., has been spending a few weeks in the hospitals of New York City.

Japan is trying to induce her farmers to take up the poultry business more extensively. Japan imports from China annually about \$500,000.00 worth of eggs.

The Long Beach doctors are happy in their new hospital, and held the meeting of their medical society there on June 26th. Dr. H. O. Bates read a paper on "Ulcer of the Stomach."

Dr. Geo. W. Harrison of Albuquerque, president of the Territorial Board of Health, after returning from a visit of several weeks to the East, has gone to the Jemez Springs for an outing.

Fothergill (1712-1780) a Quaker, and Schomberg, a Jew, had the greatest practice of any two physicians in England during the middle of the 18th century.

Dr. H. A. Johnston of Anaheim on June 20th renounced his allegiance to King Albert Edward and became a full-fledged member of the royal family under the Stars and Stripes.

According to the "*Evening Express*," Dr. John R. Haynes thinks that degeneracy is spreading over the world, and says it is increasing out of proportion to the increase of population.

Ground has been broken for a medical wing of the Pasadena Hospital, to cost \$30,000, which has been donated by O. S. A. Sprague, a wealthy citizen of Pasadena.

Dr. H. H. Koons of Tombstone, Ariz., got about fourteen miles from home in an automobile, when his machine got tired, and had to be hauled to town by two horses.

Dr. Wm. A. Duffield of Phoenix, Ariz., is spending the summer in post-graduate work in the East, and in the fall he will locate in Los Angeles for the practice of medicine.

Dr. R. W. Craig of Phoenix is spending two months in hospital work in Chicago. During his absence his practice will be cared for by Dr. Louis Dysart.

The Hemet and Idyllwild Stage Line Company have provided an elegant new white stage with white horses to make the trip between Hemet and the mountain resort for those who wish something a little nicer than the regular stages.

On the evening of June 4th the California Hospital Nurses' Alumnae Association held a delightful reception at the Nurses' Home, 1035 South Figueroa street. It was an elegant and charming affair in every particular.

At the regular meeting of the Ventura County Medical Society, held June 11th, at the office of Dr. George N. Stockwell in Ventura, the scientific program was followed by a delightful supper provided by the host of the evening.

From the district around Colon on the Isthmus of Panama during 1905 one and a half million cocoanuts were shipped to the United States. The market price of primed cocoanuts fluctuates from \$15.00 to \$25.00 a thousand.

At a recent meeting of the Orange County Medical Association held in Santa Ana, Dr. Albert Soiland of Los Angeles read a paper on "Electric Apparatus and Therapy in General Practice."

Dr. A. W. Moore has been appointed head physician at the Los Angeles Orphan asylum, vice Dr. E. R. Bradley, resigned. Dr. Bradley has done the work at this charitable institution for several years.

The opium crop of Turkey for 1905 was about 650,000 pounds. The average annual exportation of opium from Smyrna is about 225 tons, while Mesopotamia ships out at least \$500,000 worth of opium per year. A large proportion of this drug comes to America.

The Santa Barbara Medical Society held a monthly meeting in conjunction with the pharmacists at the Potter Hotel. The pharmacists of Santa Barbara were present in full force. The meeting lasted until the elegant collation had disappeared.

In 1776 Dr. Samuel Johnson accompanied by Boswell, re-visited Pembroke College, Oxford. Johnson, after a reverie of meditation, said: "Ah! Here I used to play at draughts with Phil Jones. Jones loved beer and did not get very forward in the church. Just so, just so!"

China with a population of 400,000,000, spends \$1.50 per capita per annum for shoes for the lower classes, while the expenditure for the upper classes varies from \$3.00 to \$10.00 per annum. The use of shoes in that country is steadily increasing.

At the commencement exercises of the Training School for Nurses of the Santa Ana Hospital, which were held on the evening of June 26th, Dr. C. D. Ball, the secretary, read a very interesting report of the school and the hospital, and Hon. Victor Montgomery delivered an eloquent oration.

In Nordhausser, Germany, the authori-



ties have forbidden the wearing of dress trains in the city limits, to prevent danger to health and annoyance by raising of dust. The present penalty for violating this ordinance is a fine not to exceed \$7, or imprisonment not to exceed ten days.

New Mexico and Virginia have one physician for every 1100 inhabitants, while North Carolina has one for every 1300 inhabitants, and South Carolina one for every 1200. The District of Columbia has one physician for every 280 inhabitants, and San Francisco used to have one saloon for every 150 inhabitants.

On Thursday, May 31st, Right Rev. Thomas J. Conaty, Bishop of Monterey and Los Angeles, delivered the diplomas as trained nurses to ten Sisters of Mercy at the St. Joseph's Hospital, San Diego. Dr. P. C. Remondino, president of the faculty of the hospital, spoke with feeling of the high percentage the Sisters had obtained in their examinations. Dr. Charlotte Baker and Dr. R. L. Doig also made appropriate addresses.

In India and throughout the East wheat is thrashed by being trodden out under the feet of oxen in the open field. There is consequently in the grain a large admixture of dirt. The recognized proportion of dirt allowed by English millers is 5 per cent. Before the final shipment from India the wheat is put through the mixing machine, where it receives its 5 per cent of dirt, and is then ready for the wheat market in Europe.

The Salton Sea, according to W. B. Clapp, hydrographer in the employ of the United States government, covers an area of 335 square miles. The elevation of the bottom of the lake is 287 feet below sea level. The depth of the water is now 57 feet. This matter of changing a great desert into a lake will probably make quite a change in the climate

of Southern California; it is generally supposed, though, that this lake is only a temporary affair.

The surgical staff of the Los Angeles Post-Graduate School will be pleased to operate on and pay the hospital expenses of deserving patients in Southern California who may be in need of major operations. Members of the medical profession in the Southwest will confer a favor by notifying the secretary of the Post-Graduate School, Dr. W. W. Richardson, Bradbury Block, Los Angeles, of such patients, and he will make arrangements for their proper care.

Dr. L. A. Perce, who is a prominent physician of the Eclectic school as well as a prominent citizen of Southern California, attended the Eclectic Medical Association, and through his efforts the National Association determined to hold the next National Convention in Long Beach during the summer of 1907. We are very glad indeed that these gentlemen are coming to Southern California, and we know that Dr. Perce will make good for everything that he promised them.

Dr. Charles P. Wagar of the *California Medical and Surgical Reporter* has purchased the *Los Angeles Medical Journal* and merged that into his publication. The *Evening News* says that "medical men throughout the country have for many years recognized the high standing and powerful influence of the *Los Angeles Medical Journal*." Dr. James P. Booth, the most versatile writer in the medical profession of Southern California, will transfer his allegiance to the consolidated journal.

The Lane Medical Lectures, commencing August 20, 1906, and continuing two lectures daily during five days of the week, by John C. McVail, M.D., D.P.H., of Glasgow, Scotland, on Practical Hygiene, Epidemics and Preventive Medicine, have been announced. Cooper Medical College is coming bravely to the

front with her work, and from all we can learn we believe that her facilities and attendance this year will be fully equal to that of anything in the past. The profession of the Coast are greatly benefited by these annual Lane Medical Lectures.

The *Pasadena News* makes the awful insinuation that there is a medical trust in that city. It says that Dr. Henry H. Sherk is the head of the trust and that those most intimately associated in its management are Dr. Geo. Deacon, Dr. Stanley P. Black, Dr. W. H. Roberts, Dr. Chas. Lee King, Dr. Mary E. Hagadorn and Dr. J. M. Radebaugh. We have often wondered how these Pasadena physicians could afford to ride in their handsome \$5,000.00 automobiles, but the explanation is now apparent.

The ninth regular meeting of the Medical Symposium Society of Los Angeles was held on Tuesday evening, June 12th, at the office of Dr. H. G. McNeil. Dr. Guy Cochran read a paper on "Infant Feeding." Dr. Edward Clarence Moore read a paper on "Intestinal Obstruction in Children." Dr. George Laubersheimer read a paper on "Lymphatism," and Dr. E. T. Dillon closed the scientific program on "Sarcoma of the Lung." The following officers were elected for the ensuing year: President, John C. Ferbert; vice-president, Dr. John B. Cook; secretary-treasurer, Dr. Edward Clarence Moore.

Dr. C. Van Zwalenburg of Riverside, whose account of his experience in the San Francisco earthquake appeared in the SOUTHERN CALIFORNIA PRACTITIONER for May, considers himself very fortunate. The night before the disaster he noticed that the spring of his watch was broken, and took it to T. Lundy, a jeweler opposite the Call building on Market street. The jeweler did not open his store the next day, nor for many days thereafter, and Dr. Van Zwalen-

burg was under the impression that his watch was gone forever. Nevertheless he wrote to the jeweler, giving the number of the watch and the ticket given him. On June 22nd, two months and five days after the earthquake, he was more than delighted to receive the watch by express.

The *Sunday Times Magazine* recently stated: "The latest number of the SOUTHERN CALIFORNIA PRACTITIONER contains an interesting symposium on the San Francisco earthquake by Southern California physicians, who were attending a convention there. It's surprising to note how cool, calm and collected most of these medical gentlemen were in the midst of the 'crash of matter and the wreck of worlds.' That is to say, if we are to accept, unquestioned, their own stories of the event.

"Dr. Lindley makes as interesting and readable a monthly of the PRACTITIONER as one can be that is devoted to the treatment rather than the prevention of disease." Huh!

Quite a number of Los Angeles medicos were entered in the June 29th-30th "Around the Kite-Riverside" auto-run, and among those who "also ran" was Dr. George L. Cole, concerning whom the *Times* spoke as follows:

"The Santa Ana Canyon was not so bad as many had feared, and nearly every one got through without trouble. After most had passed, the soft sand was churned up a good deal, and the later ones had a harder time of it. Several cars had to stop and wait at the foot of the hill, while one or two unfortunates pulled themselves loose, but no one was badly off except Dr. George L. Cole. His Pope-Tribune began to miss on one cylinder just as he got to the sand, and he had to stop, replace a spark plug, and back out, then try again.

In his address before the graduating class of the Training School for Nurses of the California Hospital of Los An-

geles. Dr. M. L. Moore said that the nurse should not consider her profession as a matrimonial bureau. That may be true, but physicians generally consider the nurse as the ideal wife, judging from the fact that twenty per cent. of the nurses marry doctors. Some of the most prominent physicians in America have married nurses, amongst others Charles Mayo, one of the Mayo brothers of Rochester, who now has an ideal family. Not only have thousands of physicians in the United States married nurses, but some of the most noted men in America who are not physicians. One noted instance is United States Senator Hawley of Massachusetts, whose wife had been a nurse in the Blockley Hospital of Philadelphia. So these training schools for nurses are also excellent training schools for wives and mothers.

Dr. Chas. E. French, an alumnus of the College of Medicine of the University of Southern California, who has been practicing in San Francisco for some years, is now located at No. 1914 Pine street in that city. His diploma was burned, and in fact he lost in the fire everything that he had except a small pocket case. The Doctor and his wife got out with only the clothes they had on. As both his office and residence were in "fireproof buildings" he carried no insurance. He says "We feel fortunate, though, that we both escaped unharmed." Dr. French is the clinical lecturer on gynecology and abdominal surgery in the College of Physicians and Surgeons in San Francisco. He also has charge of two clinics a week in gynecology at that college and is assistant to Dr. A. Miles Taylor in abdominal and gynecological surgery at the County Hospital.

The editor of the SOUTHERN CALIFORNIA PRACTITIONER has received a letter from Dr. Granville MacGowan. This letter was written at Seville, Spain. The Doctor, who on leaving here was showing the effects of long-continued hard work, reports that his health is

getting fine. He says "Spain is well worth while. There is little about the people that seems real new to one who has lived for a long time in California associated with the better class of Spanish people. The natives are kind, courteous, and pretty good people altogether." Although the Doctor acknowledges that he does not see as many handsome *senoritas* as he expected, he says the cities of Spain are clean and well kept, and implies that Los Angeles might be greatly improved as a resort if she were kept up to the Spanish standard. Dr. MacGowan had just heard of the death of his friend, Dr. Taggart.

The PRACTITIONER clips the following item from the report of the Executive Committee, which had charge of the very successful 1906 Los Angeles Fiesta:

"To Dr. W. Jarvis Barlow and the members of the floral parade committee we are greatly indebted for the magnificent display of the floral parade. These gentlemen have worked incessantly to obtain entries that would justify our reputation as a land of flowers, and the artistic and glorious designs of the floral decorations that were seen on that day will long live in the memory of those who were fortunate enough to witness them."

Upon his return from his Alaskan trip, Dr. W. Jarvis Barlow found a pleasant surprise from the Fiesta Committee awaiting him, in the form of a very handsome silver-mounted cocktail set. The Fiesta Committee thus gave evidence of their appreciation of his services as chairman of the Floral Parade Committee.

Our esteemed colleague, Dr. Henry Sherry of Pasadena, has been prominently mentioned as a candidate for the State Senatorship from the Pasadena district. Politics in the Crown of the Valley city are at times of the fast and furious kind, and to protect his interests and set himself right among those who do not have the pleasure of personal ac-



quaintance, Dr. Sherry has found it necessary to send out the following open statement:

"AN OPEN LETTER TO CERTAIN PERSONS,  
JUNE 29, 1906."

"A statement is being circulated by certain persons that Dr. Sherry is backed by a medical combine, whose object is to send him to Sacramento for the avowed purpose of instituting legislation that will prevent people from purchasing medicine except through a physician's prescription. Inasmuch as Governor Pardee is a member of the medical profession, why not include him in this combine? Why not also include Dr. Rowell of Fresno, who has served his constituents honestly for twelve years? Would it not also be well to include General Leonard Wood, who has risen from the ranks of the medical profession to be the intimate friend and companion of President Roosevelt?

"But why pause here? If these self-constituted humanitarian evangelists are so grieved at heart at the possibility that a physician may sit in the councils of the nation, why not shed a tear over the fact that the great Dr. Benjamin Rush of Philadelphia was a signer of the Declaration of Independence? Add a few more ashes to your panoply of grief,

for the present French parliament contains forty-six physicians. Even benighted Russia has fifteen physicians in Douma, while the glory of Germany is her medical institutions.

"If it is myself as a personality you are seeking to belittle, why not be manly enough to say so, and not seek to cast aspersions upon a noble profession, of which I have the honor to be a member? A profession which seeketh not its own, doth not behave itself unseemly, whose charity is boundless, and whose members have literally given their lives that humanity might live.

"That foolish and unwise bills have been presented in the past, and will be in the future is more than probable.

"The pure food bill is a national and not a local measure, which seeks to compel dishonest manufacturers of foods and medicines to deal with the public honestly or go out of business, and a prospective legislator who is too craven-hearted to come forward in support of such a measure is not entitled to the confidence of his fellows.

"This statement, then, of a medical combine, of which I am one, seeking legislation inimical to the interests of the public, is as false and baseless as the mind of the person in whom it originated."

"HENRY SHERRY."

## TWENTY-ONE YEARS AGO IN LOS ANGELES.

Excerpts from the SOUTHERN CALIFORNIA PRACTITIONER, Vol. 1, No. 7, July, 1886.

"This county (Los Angeles) offers peculiar advantages to the consumptive, and in fact all invalids, in the variety of its climate. From the sea-coast, with its pleasant summer resorts, where the air is moisture laden, and heavy fogs are almost of nightly occurrence, back to the foot hills, with their several hundred or thousand feet elevation, where the air is extremely pure and dry, and fogs are almost unknown; the latter is where the majority of phthisical subjects improve the fastest, although some are much benefited by spending the summer at the coast."—*Excerpt from an original*

*article by J. W. Root, M. D., Long Beach, Cal.*

\* \* \*

"This concludes an interesting and instructive series of reports by thirty-two different physicians residing in six counties of Southern California, and I feel very grateful to these busy practitioners for their prompt replies. These replies certainly teach us:

"1. Hay fever never originates in Southern California.

"2. All cases of hay fever that have come to Southern California seeking relief, have been benefited; almost all have been cured.

"3. That residence a few miles inland, in the foothills, relieves such cases as are not benefited by a residence at the seaside."—*Excerpt from an original article collated by Walter Lindley, M. D., Professor of Obstetrics in the Medical College of the University of Southern California.*

\* \* \*

"A serious evil has sprung up through the relationship existing between physician and druggist. It is an evil which works detriment to the physician, and must, in the end, react upon the druggist. The evil has been aptly designated by the phrase 'counter prescribing.' . . . What is the moral aspect of counter prescribing? As already said, it is the same as that of charlatanism, a false profession of the possession of knowledge to treat disease, and a taking of money from the sick man upon these baseless pretenses. . . . What is the remedy for this evil? The remedy upon the part of the druggist is very plain, simply to abstain from it, and confine himself to his own legitimate work."—*Excerpt from an editorial on "Counter Prescribing."*

\* \* \*

"Talk about danger from anarchists, socialists and the laboring classes,—we

assert here boldly, and with a full knowledge of the facts, that there is more danger in Los Angeles today from fights between attorneys than from all the combined classes mentioned. . . . In behalf of the good name of our fair city of Los Angeles; in behalf of good government, and in behalf of that great and glorious profession whose history has been illuminated by such brilliant men as Chief Justice Marshall, Charles O'Connor and Jeremiah Black, we ask that the members of the Los Angeles bar throw away their firearms and devote their leisure hours to the study of polite literature and to the cultivation of those social amenities that (at least temporarily) brush from a man's brain the cobwebs of care."—*Excerpt from an editorial on "The Legal Profession of Los Angeles."*

\* \* \*

The Medical College of the University of Southern California closed a very satisfactory intermediate session June 30th. The second regular session will begin the second week in October. Drs. Lasher and Utley of the faculty are now in New York and one or both of them will also visit Philadelphia, Boston and Baltimore, with particular reference to getting apparatus for our Los Angeles college.—*Editorial Note.*

## MISCELLANEOUS.

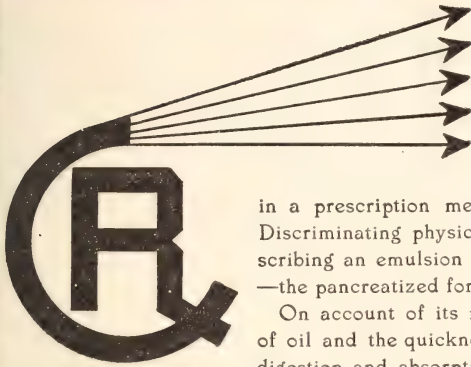
### SECOND SUMMER SESSION OF LOS ANGELES POST-GRADUATE SCHOOL.

The second summer session of the Los Angeles Post-Graduate School will commence on August 15th, and will continue for six weeks. The major groups include courses in medicine, in surgery, in eye, in ear, nose and throat, in special laboratory and in quiz work. These courses have been well arranged, and matriculating physicians will be enabled to use a part or whole of the day in

this post-graduate work, just as they desire.

The work of instruction in these various courses has been placed in the charge of conscientious teachers and demonstrators, and matriculates who faithfully attend and observe, cannot fail to receive great benefit from their work. The quiz courses should be particularly valuable in preparing for the California State Board examinations.

Those who have not yet received cat-



## What Follows R

in a prescription means much to the patient. Discriminating physicians, therefore, when prescribing an emulsion usually specify Hydroleine—the pancreatized form of cod-liver oil.

On account of its remarkably high percentage of oil and the quickness and thoroughness of its digestion and absorption, larger quantities of oil can be assimilated within a given time in the form of Hydroleine than in any other way. Hence, results follow promptly. Write for sample and literature. Sold by all druggists.

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alogues of the school should address the secretary, Dr. W. W. Richardson, Bradbury Block, Los Angeles.

The many inquiries that have already come in demonstrate the need of such an institution in the great Southwest, and as time goes on, the excellent results attained by the institution will still further prove its beneficent effect on medical development in this section.

### MILK. IT'S PURITY AND IMPURITY.

The Michigan State Agricultural College Experiment Station has issued a popular Bulletin No. 221, Part 1, on the above-named subject prepared by Charles E. Marshall and W. R. Wright, giving special directions as to its care and handling; and Part 2, "Practical Conditions for the Production of Milk," by John Michels.

Part 1 has the following outline for milk management which we reproduce for the benefit of our readers who are interested in milk, and who is not so interested?

1. The cow should be sound—no disease should exist in the animal.
2. The feed should be good and free from aromatic substance. If these aromatic foods are used they should be employed according to those methods which will not cause odors or flavors to appear in the milk.
3. The cow should be groomed and hair about the udder preferably clipped.
4. The udder should be moistened during milking.
5. The milker should be a neat, tidy person.
6. The milker should be free from



disease and should not come in contact with any communicable disease.

7. The milker's hands and clothes should be clean while milking.

8. The pail should be sterilized.

9. The stall should be such as to reduce the amount of disturbance of dust and dirt.

10. There should be good light, good ventilation and good drainage in the stable.

11. The stable should always be kept clean.

12. Feeding and bedding, unless moist, should be done after milking.

13. A dustless milking room is desirable.

14. Milk should not stand in the stable.

15. If milk is aerated, it should be done before cooling and in pure air.

16. The sooner the milk is cooled after milking, the better.

17. Keep the milk as cool as possible when once cooled.

#### MEDICAL MEN IN STATE CRAFT.

The *Medical Times* contains the following in regard to the great French Statesman Clemenceau: "In both France and Germany the medical profession is most influential in statecraft, and has risen to far higher positions than in America or Great Britain.

"Dr. Georges Clemenceau has made for himself a most distinguished position as a French statesman, and the manner in which he has met and put down the recent socialistic labor demonstration in France has won for him the gratitude of that nation. His career is particularly of interest to us by reason of his having at one time practiced medicine in this community. It is likely that, had the Franco-Prussian war never occurred or been postponed a year or two, he might have become a great American legislator, or, at any rate, an illustrious American physician.

"Now in his sixty-sixth year, Dr. Clemenceau comes of an old Vendean

Huguenot family. He writes brilliantly and with an originality and perspicacity which is the delight of those who appreciate good literature. He studied medicine with distinction at the Nantes and Paris hospitals, and was interne in each. At the age of twenty-two he wrote a work, which is still valuable, on "Anatomic Conceptions and General Physiology." In the later sixties he was a formidable opponent to the empire of Louis Napoleon, the penalty for this was that he was 'invited to leave the country.' In 1868 he reached New York, his only possession being a fine collection of surgical instruments. He became at once a practicing physician, and he laid the foundations of a substantial practice in the French colony, south of Washington Square. He also registered his intention to become an American citizen. The Franco-Prussian war and the empire's fall determined him to return to France. Lacking the money to this end, he would have borrowed some on his surgical instruments had not a friend—himself a great physician—freely offered the money without security. He made his debut in the Chambers in 1876, since which time he has been a masterful and wholesome force in French politics. In the intervals between law-making, states the *New York Times*, 'he has written much—short stories, sketches of travel, essays, novels. Among the last may be mentioned "Les Plus Forts," a study of present-day manners, aims and conditions of life, which only a man with the most varied culture and with a broad knowledge and a sympathy for the world could have written.' This great man is surely a precious possession, which our profession may claim."

IT IS SAID THAT caustic potash, three drachms to the ounce of water, applied twice a day, will cause the granulations from an ingrowing toenail to recede, when the nail can be raised and a wedge of cork inserted, affording relief.

## BOOK REVIEWS.

SECOND ANNUAL REPORT OF THE HENRY PHIPPS INSTITUTE FOR THE STUDY, TREATMENT AND PREVENTION OF TUBERCULOSIS. An account of the Work of the Second Year, a Review of the Subject of Immunization in Tuberculosis; a Preliminary Report on the Maragliano Serum Treatment, and a Report of Some of the Scientific Work Done by Members of the Staff During the Year. Published by the Henry Phipps Institute, 1906.

The second annual report of the Henry Phipps Institute for the study, treatment and prevention of tuberculosis is a volume of more than 450 pages, and like its predecessor of a year ago, gives abundant evidence of a large amount of careful, conscientious and scientific work on the subject of tuberculosis. There need be but little doubt in view of what has already been accomplished, as to whether or not Mr. Henry Phipps' foundation of the Institute in 1903 will lead to adequate returns.

Fifteen hundred and sixty-one patients were admitted to treatment during the year, 294 being admitted to the hospital department and the remainder to the dispensary department.

In the discussion of the patients under treatment, not only are such factors as nativity, age, sex, social condition, color, occupation and previous diseases fully considered, but other possible causative or correlated elements, as housing conditions, height, weight, color of eyes, size of pupils, general appearance, indoor occupation, outdoor occupation, earning capacity of patients, number of dependents, and so on were carefully enumerated, and probable or possible deductions indicated.

In the discussion of the source of contagion, Dr. Lawrence F. Flick, the medical director, states: "In nearly two-thirds of the cases of the second year a source of contagion was discovered. Family relationship still stands at the head of the list of factors in the spread of tuberculosis. More than half of the

cases contracted the disease from another member of the family, either nearly or distantly related. . . . All the data given in the tables indicate that the implantation of the tubercle bacillus is not an easy matter, and that it takes long, intimate contact for an implantation—the kind of contact which one gets in family relationship. . . . Tuberculosis no doubt got its reputation as an hereditary disease from this mode of implantation."

As to the place of beginning of tuberculosis of the lungs, the summary for two years showed the primary involvement in the right apex in 1460 cases, in left apex in 582 cases, and 302 cases undetermined. One lung was involved in 694, and both lungs in 1369 patients.

In addition to the very able general report by Dr. Flick, there are special chapters on autopsies, laryngological work, neurological work, the mental attitude in tuberculosis, dermatological report, the kidneys in tuberculosis, cardiac conditions, the liver, pneumothorax, Maragliano's serum and serum therapy, immunization of animals against tuberculosis—all of these various subjects being most thoroughly discussed and being of real interest and value.

To do full credit in a few lines to this second annual report is impossible. Each of the subjects considered is worthy of special notice. The continued progress of the work and future reports will be awaited with great interest. K.

NEVER PLACE DRY GAUZE over a wound, for the exudation even ever so small will probably dry up *in situ* without being absorbed by the gauze, thus closing the wound and preventing drainage. Gauze should always be put on slightly moist, even if afterward permitted to dry.

## THERAPEUTICAL HINTS.

### THE OAKLEY CONVALESCENT HOME.

A Los Angeles institution which came into being with the beginning of the present year, and which has been modestly doing excellent work in its particular field, is the Oakley Convalescent Home, located in a very pleasant and desirable neighborhood, at 2642 Hoover street.

The origin of this home or hospital for convalescents is due to Miss H. B. Oakley, a graduate of St. Luke's Hospital of San Francisco, who for almost ten years practiced nursing in Los Angeles, and who, during that time, made many warm friends among the medical men and surgeons of this community.

In the Oakley Convalescent Home she has made an effort to establish an institution where all the comforts of home might be combined with skillful and scientific nursing and attention. There are facilities for minor surgical operations, such as can be performed in patients' homes.

Attention has been given not only to the furnishing of this home, so as to make it restful and pleasant for the convalescent, but care is shown in the quality and service of the table as well. Members of the medical profession are always welcome to inspect the Home, which is open to all post-operative patients, or those who suffer from non-contagious chronic diseases.

Rates will be cheerfully furnished by Miss H. B. Oakley, 2642 Hoover street (Phone 21446), Los Angeles, Cal.

Dr. John H. Thompson of St. James Place, Goshen, N. Y., under date of June 4, 1906, says: "I regard Sulpho-Lythin as indispensable to my comfort. I am afflicted with a gastric trouble, and use a full teaspoonful of Sulpho-Lythin dissolved in about a quarter of

a glass of hot water before breakfast every morning."

Dr. J. W. Pearce of North Carolina recommends Papine in the treatment of diabetes mellitus. He says its effects are ideal, and that the use of it does not in the least tend to create the formation of a drug habit.

THE ACTION IN NEPHRITIS of large draughts of water is to carry off the products of retrograde metamorphosis, and hence it becomes a diuretic in a mild, but effective sense. The use of such draughts should be supplemented by hot water applications to the lumbar regions. Rheumatism may be relieved by hot applications or the hot wet pack to the back, and by hot vapor baths.

TO MAKE A HOLE IN THIN GLASS.—When one wishes to bore a hole in thin glass, in order to avoid cracking, put a ring of humid clay around the spot, leaving vacant a spot in the center, of the exact size of the desired hole; then pour into the ring a spoonful of melted lead. This causes the glass in the vacant place to break and drop out, and the lead empties itself through the hole into a vessel placed below to catch it.

INHALATIONS OF AMYL NITRITE instantaneously arrest hemoptysis. Hare has tested the action in five cases, one of mitral obstruction and four of phthisis. In every case the inhalation proved successful, and the hemorrhage stopped at once. Amyl nitrite, by dilating the vessels, relieves the blood pressure. It is similar in its action to the old plan of treating bleeding by venesection.



# *Antiphlogistine*

(Inflammation's Antidote)

Apply Hot  
and  
Thick



**Entero-Colitis, Cholera Infantum,  
Peritonitis.**

In acute inflammatory conditions of the intestinal tract Antiphlogistine will be found of great value. It will not take the place of proper diet and internal medication, but by relieving the local congestion and soothing the nervous system, it will be found to be an inestimable adjuvant.

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**THE MORTALITY OF PNEUMONIA IN HIGH ALTITUDES.**—Charles F. Kieffer refers to the very common belief that pneumonia is more fatal at high altitudes than at the sea level. Several recent papers are reviewed. The paper is a study of the cases occurring at Fort D. A. Russell, Wyoming, at an elevation of 6125 feet above sea level, during the period between 1868 and 1905. During this time among 20,569 admissions for all causes, there were 127 cases of pneumonia with 20 deaths; a mortality of 15.74 per cent. The fatal cases are classified according to the anatomic location of the disease. The writer calls attention to the prognostic import of syphilis on pneumonia. The figures are compared with those of the entire army. In the period between 1868 and 1893 the total admissions in the army for pneumonia were 7078, with 1105 deaths; a mortality of 15.61 per cent. During the same years at Fort Russell, there were 123 cases with 18 deaths; a mortality of 14.63 per cent., the advantage in favor of the high altitude being 1 per cent. Charts are included showing the incidence of the disease by months and a chart showing the mortality and ratio of incidence in the army for 36 years. The paper concludes that the figures, as far as they go, seem to show that altitude has very little influence on the mortality of pneumonia.

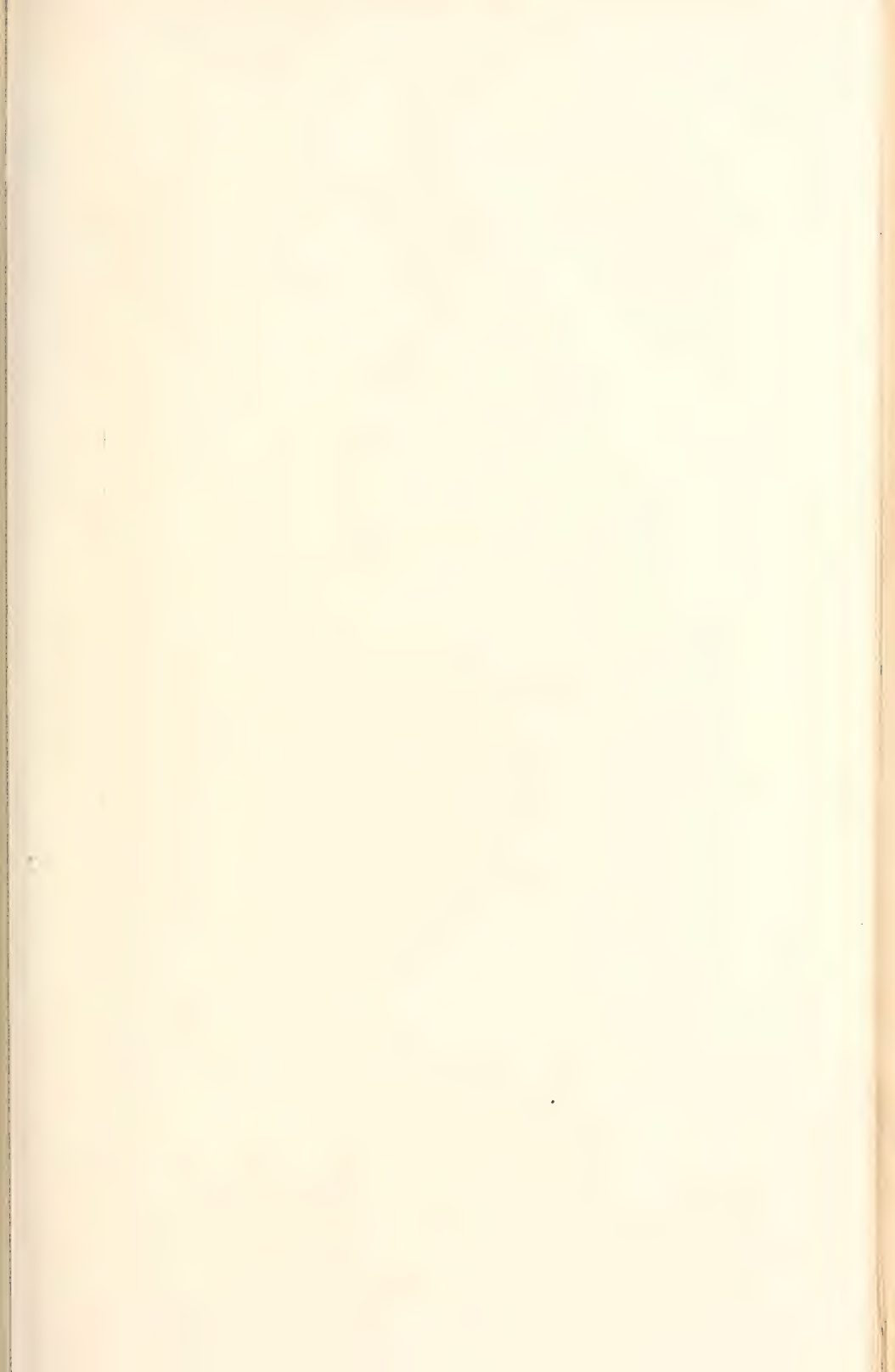
4,523,508 quart bottles of champagne were imported into the United States during 1905. During the past five years the consumption of champagne in the United States has increased over 35 per cent. The custom duty paid into the United States treasury per annum on account of champagne is three millions of dollars. Great Britain imports almost double the amount of the United States and drinks more champagne than any other nation. The United States ranks second, and Russia third. Belgium, consumes more per

capita than any other nation. The United States drinks one-seventh of all the champagne produced. The price of champagne never varies. A bottle of champagne at one of the leading hotels in Paris, where there is no duty, costs about the same as in a similar place in New York, and the price is practically the same in London, Berlin, St. Petersburg, or Rome. Champagne does not improve with age. Some of the large producers of champagne, like Pommery and Mumm, have caves dug out of the solid chalk of the earth from eight to eleven miles in extent. Summer and winter the champagne is kept at an even temperature. The grapes are no longer trodden by the feet but are crushed by machinery. The champagne drinker who has no discrimination wants his champagne sweet, while the connoisseur wants it dry. In former times the United States took its champagne considerably sweeter than now. "Brut" is a natural champagne without any artificial sweetening. "Sec" and "Extra Dry" ("Dry and Extra Dry") have a small percentage of sugar.

#### AFTER SURGICAL OPERATIONS WITHHOLD WATER.

said the late Dr. McGuire, as an empty stomach is one of the best safeguards against vomiting. Water should be withheld from the patient for several hours after recovery from anesthesia. If at the end of this time no nausea exists it may be given in small quantities at half-hour intervals, and if it be well borne by the stomach, the quantity increased until thirst is relieved. The water may be acidulated with lemon juice, or cold or hot tea, without sweetening, substituted for it.

Meirowsky has found that tattoo marks may be removed by long exposure with the Finsen light.







DR. S. A. KNOPF, NEW YORK.

WHO WAS THE FIRST STUDENT TO MATRICULATE IN THE COLLEGE OF MEDICINE OF  
THE UNIVERSITY OF SOUTHERN CALIFORNIA, WHEN IT WAS  
FOUNDED TWENTY-ONE YEARS AGO.

# SOUTHERN CALIFORNIA PRACTITIONER

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No. 8

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## THE EARLY DIAGNOSIS AND THE PROGNOSIS OF PULMONARY TUBERCULOSIS.\*

BY S. A. KNÖPF, M.D., NEW YORK.

Mr. President, beloved former teachers, former fellow-students, members of the Los Angeles County Medical Society and co-workers in antituberculosis work, ladies and gentlemen: First of all, I desire to thank you for the honor you have done me in calling this special meeting at this unusual time of the year. Here where I received most of my undergraduate training and here where there are so many tuberculosis specialists, a teacher is not needed. I do not come to teach you, but rather to learn again.

On the early diagnosis of pulmonary tuberculosis may be said to depend, in one sense, the solution of the antituberculosis problem. For the earlier we recognize this disease the earlier and surer shall we be able to cure the patient and the surer prevent the tuberculosis subject from infecting others, and reinfecting himself.

The first thing in our endeavor to arrive at a diagnosis is, of course, always to take down carefully the history of the

case; that is to say, name, age, occupation, sex, previous diseases and length of the present ailment. We were once taught to ask what the patient's father, mother, grandfather or grandmother, uncle or aunt died of. I do not ask these questions any more directly, but try to find out the answers in an indirect way, for do not forget that the moment you ask these questions directly the patient becomes alarmed and nervous, because he still believes in hereditary consumption, and in its usually fatal issue. It is of far greater import in taking down the history to ask the patient whether he has associated with anyone who had lung trouble, whether there has been any obvious exposure to infection. When the personal history reveals a pleurisy we are justified in suspecting it to have been of a tuberculous nature. Pleurisy "a frigori" is exceedingly rare.

In asking about the patient's home life try to find out something about his house and room, where he has been raised, and where he lives now, and

\*Delivered upon invitation before the Los Angeles County Medical Association, July 20, 1906. Abstract by G. H. K.

then do not forget to ask how many children there were in the family. You will be surprised to learn that when there have been five, six, seven, eight or nine children born in a family, the latter ones are more usually affected than the first ones. Young people can procreate better than older ones, on the one hand, and on the other, the first two or three children can be better taken care of in the home of people of moderate means. When more children are born, and the income is not increased, the later ones do not as a rule get the same care that their elder brothers and sisters were privileged to receive.

In taking the personal history you inquire as to diseases of childhood; affections of the lungs and pleura, pneumonia, typhoid, grippe, and other phthisio-genetic diseases; accidents; digestive disturbances; mental aspect of patient; malaise; disinclination to work and pleasure; irritability, melancholic or indifferent temperament; bronchial, laryngeal and naso-pharyngeal catarrhs.

The external appearance may give you many hints. Look for dilatation and irregularity of pupils, owing to irritation by tuberculous deposits of the sympathetic nerve on the diseased side; for chlorosis or anaemia; note the character of hair, whether dry and brittle, and whether finger nails are clubbed, or hands cold and clammy; enlarged glands, small, low irregular pulse; hair dry; margins of gums bluish or reddened, mucous membrane of throat pale; whether voice sometimes husky; whether there is pain, dull, stabbing and radiating down in the arms or between shoulder blades, or intercostal dyspnea.

Cough, if not due to nervousness or local throat conditions, is suspicious. A dry cough often precedes for months and sometimes years a cough and expectoration. Sputum at first may contain alveolar epithelia—later bacilli. Tinged sputum or hemoptysis, may be early or late and sometimes is

never present; most important and especially suspicious when not due to mitral stenosis or aneurism of the aorta or disease of the tricuspid valve. Among digestive symptoms be on the lookout for anorexia, distress, constipation, etc. Weight at its best and at present time must be inquired into.

Weight, respiratory capacity, and chest measurement have no value in establishing the possibilities of the development of phthisis in themselves, but must be considered in relation to the height of the person, when they furnish three important aids to diagnosis.

Corpulence is obtained by dividing the weight expressed in pounds by the height expressed in feet (in a normal man this should be twenty-six; in a woman, twenty-three). Thoracic perimeter is found by taking two measurements of the circumference of the chest—one at the moment of forced expiration, the other at the end of forced inspiration. The average of these two measurements should never be less than half the height.

Vital capacity is the amount of air expressed in cubic inches, which can be exhaled after a full inspiration. Normally it should bear the relation to the height of three to one for a man and two to one for a woman—i. e., for every inch of height there should be two or three cubic inches of vital capacity, respectively.

Coming to the physical examination, proper, we must always insist that the patient be stripped to the skin. No examination over a corset or several layers of shirts can be considered scientific. You inspect the patient's chest, anteriorly and posteriorly, you look for the typical habitus phthisicus, which is a stooping attitude with infra and supra clavicular depressions.

We then proceed to palpate the whole thorax. It will surprise you to see how well you can educate your hand to feel little impaired movements of the lungs.



By practice you will learn to find the slightest difference in the respiration on the two sides.

Next we look for fremitus. Please bear in mind that there is a subjective and objective fremitus. The subjective fremitus is perceived by the patient himself. Its recognition depends upon his intelligence, and upon the degree of solidification. You tell him to hum and ask him if he feels his voice vibrating. The law of physics tells us that sound is more readily transmitted by a solid body, and consequently if portions of the lungs have become solidified by the tuberculous infiltration, it will cause the voice to vibrate.

To determine the objective fremitus, we resort to the well-known means of asking the patient to say, in a sort of bass voice, the words, "Twenty," "twenty-two," "ninety," or "ninety-nine." On the right side, owing to the anatomical conformation of the bronchi, we have always a little fremitus, which is physiological. Increased fremitus not otherwise accounted for probably means an early tuberculosis. You continue to seek this objective fremitus by palpating the entire chest, anteriorly, posteriorly and laterally.

The next step in the examination is percussion. There is no better plessimeter than the finger. You can feel whether the lung is solid or elastic by the sensation imparted to your index finger, serving as a plessimeter. An instrument of metal cannot give this sensation. In percussing, do not forget that we have a supra clavicular triangle. I have seen any number of men satisfy themselves by percussing parallel to the clavicle, forgetting that the perpendicular percussing is just as important.

In examining a patient, it is preferable to have him sit on a piano stool, upright during the examination of the anterior portions of the chest, and in the attitude of the Buddhist prayer for the examination of the posterior portion. Dullness or flatness in the region of the apex is

always suspicious, but be not contented with examining simply the anterior and posterior chest. Percussion and auscultation along the axillary lines will not infrequently reveal obscure lesions. To examine these lesions carefully, have the patient raise his arms and rest them on his head.

The clavicle should be percussed by the immediate process, with a good percussion hammer, and with care you can often distinguish a difference between the two sides in pitch and duration.

In auscultating, begin with having your patient say, in a whisper, "One, two, three," to determine if bronchophony is present. Do this all over the chest. Sometimes the heart sound is transmitted when there is great consolidation. You may frequently hear a roughened expiratory murmur in the supra scapular regions. When the expiratory sound is decidedly prolonged, it is almost pathognomonic, indicating the invasions of the bacilli in that region. You listen also for the cog-wheel respiration, but remember also that this can be found in anaemic patients with contracted chests. You may hear rales and crackling sounds, according to the state of the disease.

One of the first psychic symptoms in tuberculosis, bear in mind, is the increased nervousness and irritability. During the examination one often can notice little drops of perspiration appearing in the axillary region, merely as a result of mental excitement.

You will, of course, not only examine the lungs, but also the heart. Look for displacement, observe whether there is tachycardia, whether the heart is large or small, whether there is a functional or organic murmur.

The thermometer is one of the most important instruments we have to help us in the early diagnosis, but rectal temperature is much more accurate than temperature taken in the mouth. If you do not get a rise in temperature immediately, it is often wise to have the patient

exercise for about half an hour, and if the increase is more than half a degree you can be certain that you are in the presence of pathological processes. The temperature should be taken mornings and afternoons, and if there is a constant afternoon rise, especially with a morning drop, you can be sure you are in the presence of a tuberculous patient.

Now, a few words as to the prognosis. An early hemorrhage is not necessarily a sign of a bad prognosis. Diagnostically they are, of course, of value, and if hemorrhages have occurred in a woman at the time of her menstrual period, do not believe in vicarious menstruation, but rather be suspicious of tuberculosis.

Among unfavorable prognostic symptoms must be included persistent dyspnea (non-asthmatic); also persistent tachycardia or a chronic frequent irregular pulse.

The X-rays are of just as great value in confirming a physical diagnosis as they are in helping to form an opinion on the prognosis of the case. If you have a large area of transparent tissue, you have a right to make a favorable prognosis, providing, of course, there are concomitant favorable symptoms.

Next, take into consideration the patient's temperament; if he is hopeful, cheerful and obedient, his case is more favorable. Find out where he comes from. If he has already had the advantage of climatic, hygienic and dietetic treatment, under proper medical supervision, and has not improved, the prognosis is almost invariably unfavorable. It shows that he has not reacted under the best treatment known to us up to the present time. The return of the menses in a tuberculous woman, which were absent owing to the disease, is always favorable. The marked diminution or non-return, the reverse.

Last, but not least, his pocketbook is a factor in the prognosis. How long can he live without work and worry? The poor man has always fewer chances than the well-to-do.

One word about tuberculin in diagnosis. I advise you never to use it. The cases where the tuberculin test has caused a generalization of a seemingly incipient tuberculosis are by no means rare. I personally do not approve of tuberculin as a diagnostic means because it is not infallible, is not infrequently productive of harm, and last, but not least, I would not wish to have it injected into myself, and it is well for physicians to practice the Golden Rule. If you wish to bring out the early signs, you can use potassium iodide; grains five, three times daily, for about three to five days.

If I am confronted with a case where all the physical signs sought for with the greatest care cannot give me absolute proof of a tuberculous disease, and even the X-rays fail me, but I suspect, nevertheless, a tuberculous condition, I treat the patient as if he had a true tuberculosis, treat him by the best hygiene and diet, but with no culture product whatever. I feel sure, then, that I will have done my patient surely some good and absolutely no harm. I advise you to do the same, and when you examine a patient impress on him particularly the principles of rational prophylaxis, so that he will not infect others or reinfect himself. Tell him that the sooner he puts himself under proper treatment, the greater are his chances for recovery. When you do all this, you fulfill your true mission, which is to save or at least prolong the life of the patient, make him as comfortable as you can and prevent others from contracting the disease.

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#### DISCUSSION OF DR. S. A. KNOPF'S PAPER.

DR. F. M. POTTINGER.—Was very glad to hear the able talk by Dr. Knopf. Dwelt on the necessity of making a most careful history and of making a comprehensive methodical examination. A disease like tuberculosis was worthy of all the attention we could give it. Regarding Dr. Knopf's non-approval of the stethoscope, for himself, he had never been able to get his ear down in the supra-clavicular notch. And as for the use

of a chest cloth, if clothing was undesirable lest artificial sounds be produced, why would not the same objections hold to a chest cloth?

The ordinary practitioner failed to properly weigh the symptom complex in early tuberculosis.

As to the criticism of tuberculin, while it may be good doctrine never to use remedies until they are absolutely proven, how, if they have never been used, are we to know when they have been proven? He had given over 100,000 injections of tuberculin, and had yet to see its harmful results. But granted for argument's sake, that an occasional death did result therefrom, should that debar its use, if it be a useful remedy in a large number of cases? Should we throw away ether and chloroform because an occasional death results from these general anaesthetics?

He did not believe it was right to belittle these laboratory products. To his mind the cure of infectious diseases, if cure was ever attained, would be by way of the laboratory.

Tuberculin as formerly given was improperly given. The recent work of Wright, of London, had shown that tuberculin will increase the resisting power of the body, and the leucocytes will take up two or three times as many bacilli. More and more of the German sanatoria are beginning to use tuberculin. In giving tuberculin he injects 2 or 3 mm. the first day, 5 mm. two days later if no reaction, and 10 mm. three days later if necessary. In this way a severe reaction is avoided.

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DR. J. O. COBB:—Could state from personal experience that Dr. Knopf practiced what he taught. His methods are even more exacting than those demonstrated this evening. Short cuts in tuberculosis diagnosis are to be avoided. In connection with bared chest in examination, believes that life insurance examiners are much at fault in this regard. Women also should be examined carefully, but the niceties in preventing exposure of person should not be neglected.

Dr. Knopf has said nothing about the bacillus. When the bacillus is present in the sputum, we no longer have a first stage case to deal with. The treatment for tuberculosis will injure no person, certainly no person with symptoms and signs indicative of tuberculosis. As to the use of tuberculin, he believed it was worthy of more study, and would take a position somewhere between the standpoints of Drs. Knopf and Pottenger.

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DR. GEORGE L. COLE:—Had been delighted with Dr. Knopf's demonstration. Did not desire to discuss tuberculin, but remembered a professor from the East who several years ago came to Los Angeles and asked Dr. Cole to give him a tuberculin test, but when the time came his courage failed him. The professor's reason was that it was all right on other people, but not for him. Had noted that when patients had not im-

proved in the first few months, they not infrequently did so later on.

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DR. JOSEPH KURTZ:—Would only speak upon tuberculosis from the standpoint of tuberculosis of the joints. In these cases tuberculin was not used. Here also early diagnosis was necessary, and in case of doubt the open-air life with rest locally was indicated.

Referring to life insurance examinations, stated that he had examined many hundred persons, but felt that if some poor fellow with incipient tuberculosis had not been detected and so refused, and that if this man had later died and his poor family had received a thousand dollars or so, he was glad of it, and in the face of the outrageous stealing on the part of the highest officers of these companies, his conscience troubled him little on the score of having perhaps allowed one or two suspicious applicants to get past him.

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DR. STANLEY BLACK:—Agreed with Dr. Knopf on the use of the ear as against the stethoscope. Regarding bacilli in the sputum, it was often necessary to make many examinations before one could find the bacilli. In one case he had made twenty examinations before finding the bacilli. Incipient pathologic tuberculosis was an earlier condition than incipient clinical tuberculosis, i. e., so far as demonstration was concerned. As to tuberculin, it was to be used with care, since it could cause a disintegration of the tubercular tissue and lead to a rapid dissemination of the disease.

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DR. H. Z. GILL:—Desired to ask why the microscope had not been mentioned. As early as the middle seventies Fenrick of Canada and Beall of London had called attention to elastic tissue in the sputum. That was before the bacilli had been discovered by Koch. Were these facts forgotten?

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DR. GEORGE H. KRESS:—Mention had been made of Dr. Knopf having been the first student to matriculate at the College of Medicine of the University of Southern California when it was established, twenty-one years ago. That was not the only thing he was first in. Southern California. His first medical article appeared in the Southern California Practitioner, and was signed by S. Knopf, medical student, and was written when he was a freshman. Like his later writings in the anti-tuberculosis crusade, in which he has done magnificent work in pleading for those who are in no position to plead for themselves, this first medical contribution from his pen was a plea for recognition of the scientific worth of Dr. von Gudden, who had given up his life in the attempt to save that of his royal master, the insane King of Bavaria.

His Los Angeles residence was probably the reason of his going into anti-tuberculosis



work, for in his book on the Prophylaxis and Treatment of Pulmonary Tuberculosis, he had stated in his preface that it was during his residence in Los Angeles that his attention was first attracted to anti-tuberculosis work. So that in more than one phase of medical development Dr. Knopf did his first work in Southern California.

Dr. Knopf stated that he laid but little stress on the direct family history. Was family history, however, not an important aid, and did it not in many cases throw a direct light on the source of contagion? The second annual report of the Phipps Institute, which was just off the press, showed that in more than one-half of fifteen hundred cases the prolonged contact which seems necessary to implant the disease was acquired in the family. Direct hereditary transmission, of course, was no longer believed in, except in very rare instances. An unfavorable family history, instead of depressing the patient, should be used as a lever in making a patient obey the rules and follow the mode of life so necessary to the cure of this disease.

As to the evil effects of tuberculin, the bad results of the early nineties were not a fair comparison as to its mode of use today. When Koch first brought out his tuberculin, a crude preparation was used in improper dosage upon an improperly selected class of patients. The bad results that accrued therefrom were to be expected, but it is not fair

to judge tuberculin on the results of that period, but on the present, and the present, as the reports of the German sanatoria show, demonstrates that as we learned to understand its action better it was growing more and more in favor.

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DR. S. A. KNOFF:—Desired to thank the members for their very full discussion, and felt the compliments paid him by the speakers were somewhat undeserved. As to his being the first student to matriculate in the College of Medicine of the University of Southern California, and his having written his first medical article for the Southern California Practitioner, that was true. In addition he had been the first night nurse at the Los Angeles County Hospital, and the first interne at the same institution.

The number of bacilli in a specimen were no guide to prognosis.

Regarding the use of stethoscope in supra-clavicular spaces, when he needed a stethoscope he used the old-fashioned kind, the monaural of Laennec. A phonendoscope he did not use at all.

He had discussed tuberculin from the standpoint of diagnosis, and not of treatment. Concerning its therapeutic use, he did not care to speak on an evening devoted to early diagnosis. As a diagnostic medium he was, however, opposed to it, because of its unreliability and its dangers.

## STRICTURE OF THE URETHRA.

### ITS TREATMENT, TOGETHER WITH CERTAIN MEASURES AND PRECAUTIONS NECESSARY TO OBTAIN SUCCESS IN THOSE CASES OF URETHRAL STRICTURE REQUIRING A CUTTING OPERATION.

BY GRANVILLE MACGOWAN, M. D., PROFESSOR OF DISEASES OF THE SKIN AND GENITO-URINARY ORGANS, COLLEGE OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA, LOS ANGELES.

Stricture may be defined as a lessening of the normal caliber and interference with the dilatability of a urethral canal by round celled infiltration, or deposit within its walls or in the corpus spongiosum of cicatricial connective tissue as a result of prolonged or chronic inflammation, or of mechanical or chemical injury.

These contractions are usually susceptible of dilation by instruments made of whalebone, silk, or steel, called bougies or sounds; and, after a certain increase of caliber has been

reached, say 22 to 26 F., and further progress is apparently denied by reason of the density or resilience of the cicatrix, great help may sometimes be obtained by the patient use of expanding dilators, the best type of which is that of Kollmann. Great caution should ever be preserved not to use these powerful levers as divulsors. The operator should be satisfied to advance from one-half to one number on the dial at each sitting; and the utmost cleanliness should be practiced in the toilet of the urethra and bladder, both before and

after the use of the dilator, in the asep-sis of the instrument and its cover. These dilators are dangerous machines in the hands of the careless or unwary; the canal is always brittle behind or in the site of one of these tight strictures, and I have known of quite a number of cases of rupture of the urethra occasioned by the abuse of Kollmann's dilators in the hands of over-confident or inexperienced persons doing urethral surgery.

In proportion to the very great number of strictures that come to treatment, very few require any cutting operation. It has, however, been my fate to have treated quite as many, if not more cases of stricture by internal or external urethrotomy, than I have by dilation. The reason for this is that the greater number of persons who have sought my advice voluntarily, have had strictures which were capable of dilation, while a very great number of those for many years in this city and county, and the southern part of this State, whose strictures have been regarded as impassable, uncontrollable or beyond help, have been brought or sent to me for operation by others. My external urethrotomies alone run into many hundreds, and I have ceased to keep account of them. Necessarily in this experience I have gained some knowledge of why these operations are rarely strictly curative; what is necessary to obtain the best results; and what in technique and after treatment should be avoided. It is this knowledge gained from the study of my own mistakes and the contemplation of the blunders of others, that I now endeavor to express to you.

Before doing a cutting operation, really know that such an operation is necessary: which means that you must be supplied with instruments of precision to determine the greatest degree of contraction present, its pathological nature, and its possibilities of dilation.

Positive information as to the presence and grade of stenosis, unless it is severe enough to occlude the channel from the meatus, or only allow of the passage of a whalebone bougie, may be obtained only by the intelligent use of the shouldered or bulbous bougies as stricture searchers, and of the electric endoscope. Any urethra with an approximately normal meatus should allow by gentle manipulation, aided sometimes by the relaxing effects of the local use of a little cocaine and adrenalin solution, the passage of a shouldered bougie, of a slightly less caliber than its meatus, to the bladder; and if upon its gentle return it does not catch or hang at any place so strongly as to require noticeable muscular effort to effect its withdrawal, there is certainly no stricture present, or none that can give excuse for interference by cutting. Every physician treating strictures should have such bougies in the flexible French or German makes, running in alternate numbers from 10 to 30 F., and in steel with copper handles from 20 to 30 F., the latter for use only after cutting operations, to make sure of the severance of all bands. The information obtained by a conical steel sound in examinations for stricture, is very deceptive, though it has in a half-degree the weight of the authority of Keys as a procedure, very few other urinary surgeons would think of relying upon it.

When a tight stricture is situated within an inch of the meatus, and any difficulty is encountered in dilating, it should always be cut. The instruments needed are one small and one medium blunt pointed straight bistoury, a grooved director, and some steel bulbous bougies from 20 to 30 F. The essential points in cutting are that the meatus is to be markedly overenlarged and all of the bands back of it severed so that finally a steel 30 bulbous bougie can be passed to and fro freely through

the seat of the stricture. Sometimes the stenosis extends to the roof of the urethra, but permanent benefit is not obtained by cutting the roof in this region. Afterwards for fifteen days a conical meatus sound should be passed daily through the wound to keep it dilated and in spite of this attention there will often eventually be more after-contraction than is desirable. The first few days it is best to keep the sides of the wound apart by gauze strips soaked in melted vaseline. When the stricture is situated in the urethra between the region described and the triangular ligament, it is usually best to do an internal urethrotomy. Here again we need instruments of precision. I do not believe it is proper to undertake such an operation, as I saw two physicians of my acquaintance once attempt in one of our hospitals, with three or four large steel sounds and an antiquated Civiale urethrotome that could not possibly be introduced past the face of the filiform stricture.

The operator should be provided with whalebone filiform bougies, tunneled silver catheters from 8 to 16 F., a Maissonneuve urethrotome or one of its modifications, and an Otis urethrotome, either straight or curved. The blades of these instruments should be sharp and tried in their sheaths to see if they move freely, before the patient is anesthetized; and the distal extremity should be tunneled to thread on a filiform guide. If the stricture cannot be dilated to admit an instrument the size of No. 16 F., the Otis urethrotome cannot be used. However, a filiform can almost always be passed and tunneled silver catheters of increasing sizes threaded upon it until the passage is dilated enough to take the Maissonneuve, or even sometimes the Otis. Never use great force to introduce these catheters; it is better to tie in a filiform for a few days so that the surface of the stricture may become softer and more

dilatable. When there is room for the shaft of a Maissonneuve to go by, the 26 blade may be driven home without fear. If the tip of the instrument is in the bladder and the shaft is not depressed, nothing of importance will be injured in the cutting. After its withdrawal, a warmed and lubricated steel sound of moderate size should be passed to the bladder. This may often be followed by other sounds in increasing numbers until 26 F. or even larger will pass easily, if so it is enough; for it is never to be forgotten that cutting a stricture is not curative, it is only a substitute for dilation and done for the sole purpose to make the latter possible. But if, as usually happens, only an 18 or 20 F. sound can be passed, the caliber of the canal will have to be further enlarged by cutting with the blades of the Otis instrument. When there are false passages in the urethra or enlarged follicles, or pockets in front of the strictured portion, it is sometimes difficult to guide the shaft of the Otis instrument into the bladder. If the search is prolonged it is best to replace the filiform and thread the eye of the shaft upon it. No violent effort or force must ever be used, for the man has commissioned you to improve, not to render worse, the condition of his urethra. The instrument introduced, its dilating blades are to be expanded until the dial registers 32 to 34 F., then the cutting blade is pulled through the sclerotic tissues and afterward pushed back into its sheath. The screw is now turned until the dial indicates 34 to 36 F., and then reversed slowly, while making gentle traction on the shaft, the instrument is withdrawn. By this maneuver one avoids the disagreeable accident of the dilating blades catching and holding and seriously wounding a fold of the mucous membrane of the urethra. The canal is then dilated with conical sounds and explored with the shouldered bougies to detect unsevered



bands. Even with the sharpest of blades, sometimes several distentions with the dilator and cuts have to be made in the resilient or inodular tissues before all the obstructing bands are finally severed and the desired approximate caliber of the normal urethra obtained.

An average caliber of 30 F. should be fixed as the goal in these operations, but judgment is necessary in these as in other matters. The chief requisites are that all bands shall be severed and the passage of the bulbous bougies be smooth. The urethra will always contract some in the healing of the wounds, so it is best to over cut. It is my habit, and I think it a good one, after cleaning the urethra and bladder of clots, to tie a 20 to 22 Nelaton catheter in the bladder for the first 24 to 48 hours following the operation. This controls hemorrhage and nearly always drains the bladder painlessly and thoroughly. The patient is kept in bed and the bladder washed out with normal salt solutions every half-hour for the first twelve hours, and later every four hours. Spasmodic contractions of the perineal muscles frequently occur before the patient has fully recovered from his anesthetic, thus preventing the passage of a catheter. This condition is usually overcome by a little more ether, but if not the catheter can always be made to pass by the aid of a steel mandrin. The catheter is removed and the patient is allowed out of bed at the end of forty-eight hours. A sound is not usually passed until the fifth day after the operation. This is repeated every four or five days until the wound is healed and no more shreds appear, then if no tendency to contraction reappears, sounds are passed for a month once a week, then for three months once in two weeks; then for six months once a month, and then for six months once in two months, which I think a very good in-

terval for any man who has ever had a stricture operation to pass sounds himself, or have his surgeon do so, for his lifetime.

The weakness of internal urethrotomy is the impossibility of controlling positively the amount of tissue cut by the instrument used, the good often has to be cut with the bad; the tissues are all erectile and do not remain of the same size and in the same place while the cutting is being done. When the operation is done beyond the first inch of the urethra, the incision is never in anyone's hands entirely confined to the diseased structures, except where the urethroscope may be used to bring in sight a band-like constriction which may be cut with a special urethral knife (Oberlander, Kollman,) directly under the eye.

In view of these circumstances, it is best to do internal urethrotomy for strictures:

1. When they are not dilatable.
2. If the passage of instruments is accompanied by disagreeable hemorrhage, abundant catarrhal discharge or is followed by chill.
3. First, if the patient has retention and is the inmate of an overcrowded charity hospital; second, in a condition that demands surgical interference; third, has had retention and his business requires him to be in places where he cannot get good surgical care in case of the repetition of the retention.

Where the sclerosis has implicated the greater part of the canal from meatus to bladder do not expect a disappearance of all of the disagreeable symptoms after the operation. If the stiff fibroid tube stands open enough to allow the individual to empty his bladder easily, teach him to be thankful for this; for he will not get rid entirely of the follicular urethritis, the prostatic catarrh and the vesical irritability. Under the influence of errors in diet, venereal excitement, the effects of alcohol or of

cold, the patient will suffer from exacerbations of these troubles and will plague you with complaints of the lack of cure following his operation.

Thus we are brought up to the severe strictures of the deep perineal and membranous urethra. Very few American surgeons familiar with the anatomy of this region treat these narrowings by internal urethrotomy. The danger is too great from hemorrhage and infection. In this group may also be included those strictures just beyond the peno-scrotal junction which are impassable to any instrument.

This is the field *per se* for external urethrotomy, and taken altogether forms a most difficult class of surgical operations. Perineal section is very simple when you get the go of it, but external urethrotomy for perineal stricture is at times appallingly difficult even to experienced operators. It makes much difference whether one of those little thin whalebone strips called filiforms can be passed to show you the way or you have to operate without a guide.

One should have for such an operation filiform bougies, tunneled silver catheters, a Wheelhouse staff, a long curved staff for retrograde work, one or two fine silver probe pointed directors, some eye knives, small curved Graefe eye scissors, a narrow straight gorget, perineal tubes No. 34 to 40 F. with two eyes, a Blizzard knife, needles that will carry No. 0 cat-gut, needle holder, strong blunt pointed curved scissors, good dissecting forceps, one or two good scalpels, some haemostats, a pair of uterine forceps, some soft rubber catheters, steel sounds and shouldered stricture-searchers. Compare this with the list in your books on Genito-Urinary diseases and you will wonder what these are for. In many cases the operator will need every one of them and in most cases they will expedite work that is always difficult. A good light and plenty of time is always necessary.

Local anesthesia is rarely practical. Many of the persons requiring this operation are alcoholics or opium users and are difficult to bring under the influence of ether or chloroform, hard to keep motionless and are prone to collapse. For the past four years I have almost always employed spinal anesthesia in these cases, using from one to two grains of tropococaine. I find this entirely satisfactory. I believe it is without danger, and find the help the patient is able to give me of great assistance in the search for the opening of the stricture.

In the Wheelhouse operation, either with or without a guide, the precautions necessary are first to keep the button end of the staff within the urethra. It is so easy to puncture the rotten tissue, and once outside of the mucous membrane, a staff readily finds its way between the layers of the bulb, often feels entirely free, and leads one into difficulties that may prove unsurmountable. Nearly all of the mistakes and troubles arise primarily from violence done to the urethra by the person holding the staff or the use of too coarse knives and probes by the operator. One should always open the urethra a half inch or more in advance of the constricted portion, so as to have sound mucous membrane into which to introduce the sutures used for retractors. The opening of the stricture is always tortuous and frequently eccentric and minute; it often lies among a bunch of wart-like granulations. The folly of searching for the channel with large grooved directors and incising it with coarse bladed scalpels is obvious. It is for this reason I use probe pointed and sharp pointed eye knives for this work. The Graefe probe pointed curved scissors are made use of to remove any wart-like excrescences which may be found; they can easily be taken off level with the mucous membrane with this in-

strument, and it is the only scissor I know suitable for the purpose.

Having discovered the opening, enlarge it upon the floor, cutting on the fine probe pointed director with a fine knife until a probe pointed straight gorget can be passed to the bladder; then with a Blizzard sever all of the obstructions in the bulbo-membranous urethra on the floor. Do not fear the bleeding, though it is often considerable I have never known anyone to be destroyed by it. If the incision is in the median line no arteries will be cut. If any artery is cut take it up with the surrounding bulbar tissues in a mass ligature, using a round pointed needle. Now right here is where many operators fail. The way appears clear to the bladder and they are satisfied to introduce a catheter through the perineal wound, tie it in, pack the cavity and admire themselves for breaking into the bladder so slickly. In the average case the operation is only half done at this stage. The next step is to introduce an index finger into the wound palmar surface upward and ascertain the condition of the roof of the canal within the limits of the incision and posterior to it. It is important always to save the roof of the canal as much as possible, for from a comparatively narrow strip of healthy mucous membrane on the roof the new channel formed by granulation will be covered and regenerated. But do not allow any bands to remain in this position. Cut them carefully where you can see them, with a thin bladed sharp knife in the median line, and if the infiltration extends through the urethra let the incision also extend through it so that the stiffened tissues in healing will carry a splice in the roof as well as on the floor. Where they are out of sight, cut them carefully with a sharp Blizzard guided by the sense of touch.

Explore the membranous and prostatic urethra with the finger. If there is ob-

struction to the entrance of the finger not easily overcome, introduce a Kollmann straight dilator or a Wylie uterine dilator along the gorget into the bladder, and cautiously but thoroughly dilate the urethra and the bladder neck to 40 F. There need be no fear of overstretching the bladder neck unless the operator is brutal. This procedure overcomes all spasm and irritability of the bladder after the operation, and allows of drainage through a large tube without discomfort. Sometimes there are bands of dense infiltrations of cicatricial tissue in the membranous urethra beyond the limits of the original stricture which require incision; if they are found the Blizzard is the best agent to deal with them. In elderly persons I have a number of times met with the disagreeable complication of contracture of the bladder neck, or obstructive sclerotic prostatic enlargement as a complication of severe bulbo-membranous stricture, and these must be removed by appropriate operation at the same sitting, if success is to be looked for. If false passages exist into the bladder they should be cut so as to form one channel with the urethra.

The most common stumbling block is lack of careful examination of the urethra in front of the incision. This should always be cleared of obstructions before the operation is finished. Do not depend on subsequent dilation. If there is any narrowing, cut it at the meatus with the blunt pointed straight bistoury, and further along the canal with an Otis urethrotome. Cut freely, so that a 30 F. bulbous bougie will pass freely from meatus to the bladder. Then finish the operation by introducing a 34 to 40 F. perineal drainage tube into the bladder and a full sized No. 26 F. catheter through the urethra until it can be felt in the perineal wound impinging upon the perineal tube. Fasten the catheter by a stitch holding it to the glands, and



the perineal tube by a silk worm suture passed through both edges of the perineal wound and looped tightly about the tube at a point where careful trial shows the tube is set properly for drainage. If the perineal wound is a large one, a suture may be placed next to the rectum and one or two near the scrotum, but no attempt should be made to close the wound tightly, the chances of sepsis are too great and the safety of the patient depends upon the freedom of the drainage. If the oozing is considerable, a light packing of a gauze trailer soaked in solution of adrenalin 1-1,000 and a pad under a double "T" bandage will control it.

The bladder is washed with sterile normal salt solution every half hour through the perineal tube, to prevent the accumulation of clots, until posterior active hemorrhage ceases; it is then washed every four to six hours, as long as the tube is retained, with borosalic solution, and after the removal of the perineal tube, which takes place in from two to six days, according to the condition of the urine, each time a sound is passed, with solution of silver nitrate 1-30,000 until the urine is clear. The tube is removed from the anterior urethra on the second or third day, and the subsequent treatment is that detailed under internal urethrotomy. Urinary antiseptics, urotropin and santal are used in small doses three times daily, the former between meals in solution, the latter after meals. Immediately following the operation, or while the patient is still upon the table, two liters of normal salt solution is introduced beneath the skin and this is repeated in from four to six hours. Since adopting this measure nearly ten years ago, I have never seen even in the worst cases, any flagging of urinary secretion or urethral fever follow the operation. Subsequent sounding should be repeated at intervals of four to five days until the external wound is healed. This takes place in from

two to six weeks, and after the first week, usually proceeds just as well with the patient up and about as it does in bed.

The congestion incident to the pressure of the full bladder upon the veins of the penis will, when removed, often convert an impassable stricture within twenty-four hours into one that is easily passable to a filiform and a tunneled catheter. There are two ways of accomplishing this: One by *sectio alta* and drainage by a De Pezzer catheter stitched in the bladder by the Gibson method. This is easy and may be nicely done under infiltration anesthesia. While the bladder is open a retrograde staff may be passed into the posterior urethra from the bladder to the face of the stricture, the perineum and urethra freely opened on the staff and a drainage tube inserted, after which the suprapubic bladder wound may be closed. This is rather a common procedure in France and presents no great surgical difficulty.

In stricture impassable to all instruments, the safest way of gaining entrance to the bladder from the perineum is to make the inverted "Y" shaped incision, and after exposing the bulbomembranous junction, cut off the rectourethral tendon and enter the urethra at the apex of the prostate. A gloved finger in the rectum may press the urethra, which the trained finger can easily distinguish, against the pubic arch, a straight sharp scalpel with the cutting surface up can usually be readily thrust into the canal and a small straight gorget passed beside it to the bladder, after which the opening may be enlarged with a Blizzard until a good sized drainage tube can be inserted. Often after drainage for a few days, an internal urethrotomy may be done in what was considered previously an impassable strictured canal. This is sometimes more difficult than it is to tell of, for the anatomical relations are not infrequently greatly distorted by the inodular masses,

fistulae, etc., which have practically replaced the bulbar tissue, and tied down muscles and fascia so that they cannot be separated or retracted. In the final dealing with these conditions all of the cicatricial deposit must be removed with knife and scissors, and all fistulae split up and dissected out before the operation can be considered finished. It is well always to save the roof if it can be done, but if it is hopelessly cicatricial with the rest, it, too, must be resected and the divided ends of the urethra brought together over a catheter, which I have done successfully several times; or the ends united by grafts, a procedure which has never succeeded for me.

In these old and desperate cases do not look for a 26 F. urethra. Your pa-

tient and you will both be fortunate if you succeed in establishing a 16 F. that will remain patulous, and permit of fairly comfortable passage of urine.

As a final admonition, never fail after an operation for stricture, to search the bladder and prostate for stone. Be prepared always after an internal urethrotomy to crush a calculus and remove it, if one be found, at the same sitting. In an external urethrotomy if the stone be a small one, it may be removed through the perineal opening with a pair of stone forceps after the bladder neck has been dilated as directed. If it be a large one, it is best to crush it and pump it out with the excavating instruments. This procedure is very easy of execution if the surgeon is properly equipped. Suite 539, Douglas Block, Los Angeles.

## ALBUMINURIA IN PREGNANCY.\*

FRANK W. THOMAS, PH. M., M.D., CLAREMONT, CAL.

One of the most important disorders incident to the pregnant state is that of albuminuria. It is manifested in different forms or types, ranging all the way from simple periodical traces of albumen in the urine to those extreme conditions where albumen is both constant and abundant, and where hyaline and other casts are present to indicate the seriousness of the attack.

Albuminuria is really only a symptom which may or may not be attended with structural lesion of the kidneys. All known lesions of the kidney—every variety of nephritis—may occur in pregnant women as in any other person. In some women, renal disease is present when gestation begins. While some cases are thus accounted for, there are others in which renal disease only begins during pregnancy, and disappears after delivery. It is this last class that is difficult to explain. That the morbid con-

ditions observed are in some way produced by pregnancy cannot be denied, and that previously existing renal disease is made worse by gestation is equally true. Theoretical explanations that explain some cases fail to explain others. While gestation is ordinarily regarded as a natural process, there is undoubtedly in many cases a toxic element circulating in the blood. Whether this poison is from the fetus or the mother, or from both, has not yet been determined.

If the regular examination of the urine is made at stated intervals, as it should be in all cases of pregnancy, especially during the latter half of the period, albumen will sometimes be found before any other marked symptoms develop. If this discovery is not made, and albumen should appear in the urine to such an extent as to constitute a serious case, we may expect such symptoms as

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swelling of the feet and limbs, extending later to the upper extremities, and possibly to the face. The urine becomes high colored, diminished in quantity, and in extreme cases is completely suppressed. The microscope may reveal tube casts and blood corpuscles; and when the nerve centers become poisoned, there is headache, vertigo, ringing of the ears, vomiting, epigastric pain, with derangement of special senses, as impaired sight and hearing, while the breath and perspiration may have an ammoniacal urinous odor. Unless these symptoms are relieved, uraemic convulsions will probably seize the patient, while stupor, coma and possibly death may follow in rapid succession.

The frequency with which this disorder manifests itself varies; opinions range all the way from 5 per cent. to 50 per cent. of all pregnancies. These different conclusions are no doubt due to the different methods adopted by observers in collecting statistics, and to the different stages of pregnancy in which records are kept. Observations made during the last three months would show far greater frequency than those of the first three months of gestation. Again, there are other factors that contribute to these different results obtained, such as care and accuracy of observation, the character of the test employed, as well as the race, and habits of life of the patients, especially as related to diet, exercise and constipation. It is sufficient to know that he who practices the obstetrical art should be on his guard in every case committed to his care, to discern the earliest trace of this disorder, and avert it if possible.

The importance of this subject is not questioned by anyone in the profession, but when we come to the etiology and pathology of this morbid process we find a difference of opinion which clearly indicates that the mystery of this disorder is not yet fully understood even by the wisest of pathologists. But some of the twentieth century medical

light has revealed conditions and facts along this line that give us better ideas of the nature of this trouble than formerly, even though positive proof is yet difficult to present.

Theories that are advanced as to the cause of albuminuria in pregnancy may be divided into two classes: Theories of mechanical pressure and those based on quantitative or qualitative alteration of the blood. Late observers are inclined to abandon the pressure theory, and seek to explain the condition by changes in the circulating blood, but the question is yet under discussion. It has been well said that whether the blood serum of a pregnant woman is more toxic than usual or not, there can be little doubt that the presence of a living fetus in the uterus is accountable for the presence in the circulation of certain products, causing headache, nausea, and vomiting, and even hyperemesis gravidarum, with accompanying changes in many of the abdominal organs. Eclamptic attacks usually cease with the death or removal of the fetus, and the disappearance of the albuminuria under the same circumstances has been demonstrated.

The mechanical pressure theory explains the condition from the pressure of the gravid uterus on the renal blood vessels, especially on the veins. All admit that this mechanical pressure predisposes to, if it does not excite, disease, and is based upon such facts as these: Albuminuria is more common in the latter half of pregnancy than in the first half. More cases exist among primiparae, in whom there is great abdominal pressure from the rigid, unyielding abdominal walls. Albuminuria is greater in twin pregnancy; it is also common when there is a severe pressure from large uterine fibroids, or from ovarian cysts. It is less frequent during gestation than during labor when pressure is greatest; it diminishes after labor or rather after the removal of the abdominal tumors. Any cause that brings about renal venous stasis pre-



disposes to and excites nephritis, as in valvular defects, pulmonary emphysema, or pregnancy.

In most cases of eclampsia and pre-eclamptic toxæmia there are marked signs of involvement of the kidneys and general circulation—as manifested by scanty urine in proportion to the intake of fluid, the early appearance of pronounced albuminuria, and the presence of casts and oedema.

In the *American Journal of Obstetrics* for 1905, Stewart in an elaborate article explains the kidney trouble as follows: 'That the conclusion is not far fetched that in the cases of simple albuminuria the pressure of the enlarged uterus upon the intestines produces sluggishness in peristalsis and consequent constipation; this in turn causes retention of the products of composition, their subsequent absorption into the general system, and thus additional work is thrown upon the kidneys; the consequent effort upon the part of the kidneys to throw these products out of the system would in time produce hyperæmia of those organs, kidney fag, and hence albuminuria. The processes which result in albuminuria are probably identical with those which produce nephritis. The process means in its simpler stages, simple albuminuria, with restoration to the normal by simply unloading the intestines and liver; in its severer forms, in those cases in which the intestines are neglected or the digestion is overtaxed, the albuminuria does not yield so readily, and the condition is not easily relieved. In the still severer forms hyperæmia becomes more persistent, and then occur red blood corpuscles, leukocytes and casts, and nephritis.

Judging from these conclusions, the pregnant woman is no more liable to disease or disturbance of kidney function than the non-pregnant woman. The pregnant woman may have albuminuria or nephritis from causes which would be operative in the other case, and which

would have no reference to pregnancy.

This theory renders the hepatoxæmias and autotoxæmias secondary factors, and removes them from the category of primary or essential causes.

It is probably true that the majority of medical men look upon eclampsia as coincident with, if not consequent upon, renal disease, and that they consider the condition of the urine of the greatest importance in the diagnosis of impending eclampsia. Many investigators have brought forth strong arguments to prove that eclampsia may occur independently of the presence of albumen in the urine; and that albuminuria is much more frequently present during pregnancy, labor and the puerperium, than is generally supposed; so that deductions drawn, as to the patient's condition, based on this abnormality alone are difficult to make, and questionable when made.

Extensive and valuable investigations of this subject have recently been made at many of the large hospitals, both in Europe and America. At Johns Hopkins, nearly one thousand cases were given careful observation and study from which to gather data. In the study of the blood of pregnant women it is found that there was a moderate decrease in red blood corpuscles rather early in pregnancy, remaining subnormal throughout the middle month, to rise again to normal at the end of pregnancy. Hemoglobin was low during the first seven months. A slight absolute leukocytosis exists in every case of pregnancy, but no variation from normal in the different forms of colorless corpuscles, the leukocytosis affecting all forms of white cells alike. The specific gravity is high at the outset of pregnancy, diminishing at the middle months, and returning to normal at term. These observations show that some disturbance in the circulation exists, which makes it all the more easy for pathological conditions to manifest themselves.

Concerning the direct question of al-

luminuria, some of their conclusions were as follows: Albumen is noted in the catheterized specimens of urine from about one-half of all pregnant women. Casts apparently occur with greater relative frequency in multiparae. At the time of labor, albumen when present was greatly increased in primiparae, due probably to muscular work and increase of blood pressure during labor. Casts were sometimes found during pregnancy, labor and the puerperium without the presence of albumen; but two-thirds of the cases showing casts at the time of labor presented albuminuria at that time. Albumen was present in all cases of eclampsia. The cases of hyperemesis gravidarum showed much albumen and many casts, which strongly points to its toxæmic character.

Nausea and vomiting had been noted in 20 per cent. of the primiparae, and 33.3 per cent. of the multiparae, who later showed albuminuria; and oedema was present in one-third of these cases.

In multiparae where there was no definite rise in temperature during the puerperium, the duration of the albuminuria post-partum seemed to vary with the time of onset during pregnancy, early incidence being for the most part associated with long duration. In only one case was albumen noted late in the puerperium when not of long duration in pregnancy, and this was after curettage for subinvolution.

Ewing's report in the *American Journal of Obstetrics* for 1905, of his studies concerning these subjects for several years past, presents some very significant conclusions. He maintains that in cases of eclampsia there are hepatic lesions with clinical manifestations of toxæmia of pregnancy, hemorrhagic hepatitis occurring in practically all typical cases of acute fatal eclampsia at term, and in at least 95 per cent. of all cases of any variety of eclampsia, and is pathognomonic of this type of the disease. The liver is usually found to be

normal in size, and reduced in consistency, while the surface and section present many minute hemorrhagic foci. Microscopically there is a uniform and intense granular, hydropic appearance, and fatty degeneration of the liver cells, which results in the abolition of their function.

A case was reported showing the relation of acute yellow atrophy to these conditions, where the patient was 21 years of age, and four and a half months pregnant. There were headache, epigastric pain and vomiting, with slight fever, epistaxis and jaundice, followed by muscular twitchings, convulsions and death. The urine was free from albumen and casts, but contained leucin and tyrosin. This case fits neither type accurately of eclampsia or acute yellow atrophy, but serves the purpose of illustrating the connection between the two conditions. The autopsy showed the liver reduced in size, mottled red and yellow, with slight granular and fatty degeneration.

Several fatal cases of acute leukaemia following pregnancy were reported. The lesions in the liver were those of acute yellow atrophy, with extensive necrosis. Two facts seem to connect acute leukaemia and the toxæmia of pregnancy. First, the occurrence of leukaemia shortly after pregnancy, which seems to be too frequent to be explained as a mere coincidence; and second, the presence of leucin and tyrosin in the urine, both of leukaemia and of the toxæmia of pregnancy. Other cases suggest that the toxæmia of pregnancy may have an important relation to the severe anaemias which sometimes follow parturition, and to bear a fundamental relation to puerperal sepsis.

Ewing believes that the disturbance of nitrogeous metabolism which is responsible for the clinical manifestations of the toxæmia of pregnancy, is a failure of oxidizing capacity on the part of the liver. The proteid derivatives, which

are normally converted by the liver into urea, are no longer combined, but circulate free in the blood in poisonous form, and are to some extent excreted by the kidneys. Other proteid derivatives, as those containing sulphur, also fail to be oxidized, and contribute to the toxæmia. The blood in acute yellow atrophy often contains large quantities of leucin, tyrosin and lysin.

The complex nature of the source of these poisons renders less obscure the fact that the clinical manifestations of the toxæmia of pregnancy vary from mild vomiting to acute yellow atrophy.

Present studies of the toxæmia of pregnancy and of many other clinical conditions, furnish abundant evidence that the morbid process in acute yellow atrophy is of frequent occurrence, and is often followed by recovery.

The urinary changes indicate chiefly deficient oxidization of proteid derivatives. Albumen and casts are sometimes present, but may be absent in dangerous stages of the disease, and even in fatal cases.

After carefully reviewing the literature on the subject, it can be said that the present view of the toxæmia of pregnancy classes the disease as a functional disturbance of the liver, usually attended by severe anatomical lesions of this organ; and secondarily by functional and anatomical disturbance of the kidneys and other organs. The production of urea is now regarded as exclusively a function of the liver. While disturbance of the kidneys exists from the first, it only becomes pronounced when poisons resulting from failure of oxidization cause degeneration, congestion and exudative inflammation in these organs. Hence the disease may be far advanced before albuminuria appears. As the disease is originally a functional disturbance of the liver, cases are found with very slight lesions of that organ.

A thorough study of eclampsia in the great Leipzig clinic for the year 1904-5

seems to prove that the cause of eclampsia is a poison which is formed within the patient's body, and circulates in her blood. The poison attacks the epithelia of the parenchymatous organs, damages the heart muscle, and seriously disorganizes the blood.

In connection with these studies it was found that eclampsia differs in frequency and mortality in different parts of the world. In Wurtemberg and Vienna it is much less frequent than in other parts of the continent of Europe. This is explained by the free use of light wines and beverages containing the tartrates of sodium and potassium, which combine with the basis in the food, preventing the formation of lactic acid. This is in accord with facts noted by many observers, that the condition of the patient suffering from these poisons has almost invariably been benefited by stimulation of the excretory organs, other than the kidneys. This would appear to be a strong argument in favor of the intoxication theory that some poison circulates in the blood. There seems to be no definite proof that the toxæmia is secondary to the kidney condition, but rather coincident with it. And so it seems reasonable to accept these views held by some of the ablest men in the profession today, who have reached their conclusions only after long and profound study and investigation of a large number of cases, which enables them to speak with authority in bringing light to a subject hitherto obscure, and not yet fully understood.

*Treatment:* The length of this paper will not admit of an extended discussion of this phase of the subject, but we wish to call attention to some of the general principles involved concerning which there is at least a reasonable degree of unanimity.

Prophylaxis is of chief importance, and is probably best accomplished by careful regulation of diet and habit, with a proper stimulation of the eliminative



processes of the body through the kidneys, bowels and skin. Most authorities agree that milk is the best fluid diet, either chiefly or exclusively, as indicated, because it is not only nutritious, but it has a diuretic effect, and leaves but little unabsorbed substance in the intestine. Strict limitation, sometimes exclusion, is to be placed upon meat and eggs, while fruit and vegetables are encouraged; sugar and starch may be permitted, and a free use of effervescing beverages, especially those containing the tartrates and carbonates of sodium and potassium, seem to do good. The daily warm bath and saline laxatives are helpful, and the free use of water, plain or lithiated, is to be recommended for diuretic effect. Hot baths in suitable cases are very helpful in stimulating the secretions, but the weak heart must be guarded, and proper distinction made between the anaemic and the plethoric patient, in the use of hot baths, or any drastic measures, such as violent cathartics, or diaphoretics.

In actual treatment, diuretics and laxatives are indicated, but in case of convulsion, it should not be forgotten that there is danger in using narcotics, especially chloroform, for an indefinite period, as fatty degeneration of the heart muscle and epithelia of secreting organs

have been observed in these cases. Opinions differ as to the advisability of profuse sweating, and pilocarpin is of doubtful use. Subcutaneous infusion of normal salt solution serves a double purpose, first as a diuretic, and second as a cardiac stimulant, and is entirely free from objectionable features, except where oedema is present or where the patient is decidedly plethoric. In such a case venesection might be of great benefit, if no loss of blood has occurred. Drinking large quantities of water and flushing the bowels with copious enemata produce good results.

Making careful estimate of the amount of urea present at any stage of the disease is of great advantage in instituting proper treatment, or in making a prognosis of the case.

Should the symptoms grow worse in spite of vigorous treatment, and the nervous system become involved, as manifested by severe headache, vomiting, dizziness, or derangement of the special senses, premature delivery should be induced without delay. While authorities differ on this point, it would seem wisest to be too soon rather than too late when the patient's life is so seriously threatened.

## THE CLIMATE OF HAWAII—IN GENERAL AND IN PARTICULAR.\*

BY E. S. GODDARD, M. D., MEMBER HAWAIIAN TERRITORIAL MEDICAL SOCIETY, MEMBER AMERICAN MEDICAL ASSOCIATION, MEMBER INTERNATIONAL ASSOCIATION OF CLIMATOLOGISTS, HONOLULU, HAWAII.

In speaking of the climate of a country, one should consider it in its entirety, the sum total of several different local climates expressed as a whole.

This composite serves its purpose for a very general statement. But in Hawaii, as in a few other countries, each locality will persist year after year in

having its own climate, which persons who come here for meteorological information will be able to enjoy—or endure, as the case may be, only by going from one place to another, never being able to test the climatic possibilities of two different sections at the same time. The mean average of the tem-

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perature of a country may be as misleading, then, as that of rainfall or wind velocity, although the figures themselves remain strictly accurate. However, I think that such statistics regarding Hawaii's climate convey a more correct impression of the general and particular truth than similarly arranged statistics do for any other country. Let us say that our mean average temperature is 75° F. The extreme range in summer is from 70° to 89°F., and in winter, from 54° to 76° F.

Always the temperature of the islands is lowered by the cooler waters that reach here from the arctic seas; a fact demonstrable by comparison of our sea temperature with that of waters in similar latitudes.

Capt. Nottage, by mental and physical inheritance well qualified to find fault with all that appealed to his senses, made a good point not previously noted by travelers when he said: "The highest daily range ever known in Honolulu, during the twenty-four hours, is 23 degrees, though the average is from 10 to 20 degrees only. After the most careful search I cannot discover a lower record temperature than 54° F., or a higher shade of temperature than 89° F. in Honolulu. There is no humbug about these figures, as they are not compiled to advertise the place."

The trade winds are said to blow in the summer, but as a matter of fact, in most places subject to them at all, they prevail nearly all the year round. They are seldom disagreeable, disseminating and dissipating the heat with wonderful rapidity. In a wind record taken in Honolulu in 1891, we find that there were 249 trade-wind days, 85 variable, and 31 calm. The occasional Kona, or south winds, are an annoyance surely, but they are in the nature of storms, have no regular periods, and may skip a year now and then. While they seldom do more damage than to blow down a few banana trees, the temperature changes induced

by them are conducive to colds and exceptional malaise. This is why the native, ever fertile in nomenclature, calls the Kona the "sick wind." In a locality like the Kona's the night or mountain wind comes with regularity and energy. Its influence is beneficent if ordinary common sense is used in dealing with it, but a careless patient may increase his invalidism easily by improper exposure.

Let us consider a few figures regarding our climatology for September, 1905:

Mean temperature, Island of Hawaii, at average elevation of 1,078 feet.....	72.6°
Maui, elevation 815 feet.....	73.4°
Oahu, elevation of 350 feet.....	76.3°
Kauai, elevation of 161 feet.....	77.3°
Molokai, elevation of 435 feet.....	76.4°
Mean temperature entire group, average elevation 639 feet.....	74.8°
The highest monthly mean was....	80.4°
Lowest monthly mean .....	54.2°
Highest recorded (Kihei, Maui).....	94.0°
Lowest recorded (Mokuuila, Hawaii) .....	37.0°
Absolute range, entire group.....	57.0°

The average precipitation for the entire group for September was 8.31 inches, but Honomanu Valley, Maui, got over thirty-three inches, while some stations recorded only the forty-hundredth of an inch. The monthly mean for my own district of Kona was: Temperature, maximum, 78.6°; minimum, 64.2° Total rainfall, 6.35 inches. This is at an elevation of 1350 feet. Different pressure, temperature and rainfall may be secured by traveling up or down the mountain side. Or you may change the record by selecting special topography.

This valley here is hot and absolutely windless, so far as trades go. Up there it is cold, and the mountain breeze whistles through your whiskers. If you want your patients to get well, send them to the right place. Down in Kau they have fog you can cut with a cane knife, and over at Puuanahulu a case of pityriasis would never get moist. Climate is above flattery. It will never adapt it-

self to the wants of your most distinguished patient. He must go where the climate is in the habit of supplying the sort of weather he is looking for.

The general character of a climate may be compared to the character of a man. When you speak of him you say that he is good or bad, a pleasant or a disagreeable man, according as his many traits average up. When you say that he is good you do not mean that he is always commendably so. His mean average may sometimes be pretty low. He has his moods, there are days when he is cross and inconsistent, and many periods in the course of his life would better never be calendared. But to the friend who makes inquiries about the character of Mr. Ball, you do not specify his blemishes. You do not refer to the time Mr. Ball lost his temper unjustifiably, or mention the fact that he occasionally has the blues.

You are proud to be able to say that Mr. Ball has a character which measurably sustains itself in the community in which he lives; that your commendation will be endorsed by the local church and bank. Someone has said: "Hawaii has one of the very few nearly perfect climates, nearly perfect, and perfectly healthy."

We can say that the general character of the climate is good, pleasant, salubrious, and, by those who know, our statement will not be considered exaggeration. We can tell the stranger our experience as well as show him the figures. We are not afraid to ask the inquirer to come and see for himself.

I had not been in Florida many days before I was handed a table of maximum, minimum and mean temperature records. They read very well in the bright November morning, but I glanced at the man who gave me the paper and said: "You look sick. Were you an invalid when you came to this country?" "Not by a blasted sight," he answered, quickly. "I came here a

healthy man, enticed into the country by those mean averages, and I've got so mean and average that I haven't faith in any climate that can't show anything better than a temperature record."

But, gentlemen, you must remember that even the climate of Hawaii has made mistakes, and is liable to make them again; that its good things do not come with infallible regularity; that its general character is affected for better or for worse by places and conditions.

And this fact, which often escapes the notice of the globe trotter, and even of the invalid who is looking for a climate that will help him, and him alone, this fact, I say, needs to be remembered by us. A climate is unchangeably changeable. It is what it was a thousand years ago. If the weather you struck in Kau was said by the oldest resident never to have occurred in his remembrance, it is possible that his great-grandfather said the same thing a hundred or so years before. Despite heavy forests and deforested areas, dry soils and irrigated ones; despite the prognostications of meteorological prophets, rigidly scientific men, or the astronomical soothsayers, rest assured that Kau's climate will be what it is now, and Kona's will continue to be the best in the world.

Last year was a very dry one in this district; it was so dry that several of the citizens of Kona took to drinking whisky as a saving. The oldest white resident said that he had never seen the like, but a native who was older told me that *nui mamua* he had seen a time like that (*likipu kelo*). Such are the inherited tendencies of climate which we must study carefully before we submit our delicate patients to them. And as we have seen, they are often most unaccountable. When we first came to Kauai someone said to us: "Next month will be the lovely month of the year. It is Lowell's June, even here." It began to rain on the first day of that month, and rained every day of the month; a



wet, windy, cold, disagreeable thirty days to be sure. Then a kamaaina told us that ten years before, the weather had broken loose upon itself in this style. Two years after this, Lihue was windy, Koloa calm and dry, and Waimea wet and windy. Think of it!

We who fixedly believe that the leewards are always warm and dry, and the windwards the reverse. And we who live in this favored climate should know how little a man may judge of a specific local climate by the generalizations of the meteorological records.

Yet we read our books on health resorts, and without any real knowledge of the adaptability of a particular climate to the case in hand, we send it to Arizona, or Egypt—or Kona. It is true, of course, that the windward sides are wet, windy and cool, the leeward, dry, calm and warm. Places between the two partake of the character of each. Then the temperature and rainfall, as we have seen, vary, according to situation and elevation. From a hot beach at Kailua you may ascend to a cool house in Holualoa, or a cold one at Greenwell's mountain house. At the sea level you may not need an umbrella for months, while as you climb the side of Hualalai you strike heavy daily showers—and they strike you.

But it is the way of the world—the higher a man gets the more blessings he receives. His very prominence arrests them. And it is a very dependable arrangement for men as well as for climates.

As to rainfall, there are occasional dry wet seasons, and wet dry seasons, with as much accountability as the blues. In 1890, Honolulu got 43 inches of rain; in 1894, only 15. It is safe to say that we have no thunderstorms, yet a few years ago genuine Hawaiian lightning killed two persons in Koloa; and one in Kona. Last winter we had a clap of thunder which sent all the chickens to roost, and started forty-nine (more or less)

mangy Portuguese dogs with their tails between their legs toward South Kona. In Kona it never rains in the morning, but last year for three weeks it was wet forenoons and dry in the evening. It is also true to say that here we have no fogs. But the day Mr. T. got here (he had been traveling all over to find a fogless belt) a weird, white mist drove up the mountain side and surrounded Mr. T. for three days.

I have had occasion to read several of the reports sent home by invalids who came to California for their health. They arrived in the rainy season, when it was raining. They had dyspepsia, suffered from homesickness, and perhaps got into a third-rate hotel. Then the climate suffered. They sent their home papers full accounts of the "so-called glorious climate of California," and continued: "It rains most of the time. The streets are one vast mudpuddle, and I am shivering from the cold, which is moving at the rate of twenty miles an hour—I leave tomorrow for St. Louis."

To judge impartially of a climate one must not only consult the records far back, but live in that climate with a cheerful, patient, sanguine disposition. One must, if traveling, remember that home with all its cumulative comforts and interestedness, cannot, like a blanket, be carried from place to place.

A person away from home, afflicted with disease, is very apt to be in such a state of feeling that nothing can please him; not even a contemplation of the heavenly joy to which he is hastening. How could such a person endure a month of wet, windy weather such as we had in Kona two years ago?

A phthisical patient said to me at that time: "I've caught cold ten times since I came last month. I didn't get rid of one, and now I've ten colds piled one on top of the other. We've had three foggy days, ten windy ones, and the Lord knows how many wet ones. Pretty good record for a place that has the ideal climate of the world! If Chi-

cago has any worse climate than this, it's darn bad."

It was a mistake to send such a man here. His strength and his philosophy were gone. There was no climate for him but that of home, wherever that might be.

For, no doubt, the two districts of Kona have a very ideal climate, "nearly perfect and perfectly healthy." At, say 900 feet, the rainfall comes generally at night, there is little barometric change from year's end to year's end. It is never hot. There are no fogs; no winds to speak of; no dust, no mud. Such is the particular character of Kona.

Yet people die here of tubercular disease, too. And some patients who come here with lung trouble grow worse instead of better. There is no climate for all cases, even of the same disease, and each case should be considered as well as each climate investigated before the one is used to help the other.

There are localities here with conditions to suit all cases of tubercular phthisis. But there may be no provision for the necessary care and treatment of patients, and rather than be

subject to the lack of these, the patient had better remain in a less favored locality.

When Hawaii is provided with adequate sanatoria, I believe that it will not be necessary to send a single case away to another climate. Not only this, but we shall be able to offer climatic advantages to many outside cases of acute and chronic disease. At present we can offer nothing but the climate.

It is folly for a delicate invalid to wander about for his health, eating at boarding-houses, restaurants, or hotels which make no provision for his needs, and indeed, do not want him around. Like all therapeutic measures, climate is only an auxiliary. Without adjuncts it is usually negative in its effects.

In the best of climates there are hygienic laws to be carefully observed; regular habits, enough exercise, and not too much, at the right time, in a moderate way; properly ventilated rooms and beds, daily baths, suitable clothing, water and food, cheerful surroundings. You think that these things will insure health most anywhere. If so, they are indispensable to perfect restoration here.

## OBESITY.\*

BY T. HAROLD SUNDE, LOS ANGELES, CAL.

**HISTORY.**—Obesity is not a new condition, it must have existed in the earlier civilization, although of course, in the least degree during that early period when man procured his food by hunting and fishing and lived in the crudest fashion. However, we find evidence of its existence in the early mythological figures of the well nourished Bacchus, Selim, etc. Hippocrates recognized the harm caused by excessive obesity and spoke of its tendency to cause sudden death. To combat obesity he prescribed a hard couch, hard physical exercise before breakfast, a vegetable diet; especially the ingestion of

greens, hardening the body in the open, and the prohibition of warm baths and the use of wine, unless largely diluted with water.

During the middle ages no attention was paid to obesity and even in the 17th and 18th centuries nothing can be found in literature that could aid us in combating this condition. Isolated cases were reported here and there; one interesting case on account of the treatment is of a German Prince who wishing to be relieved of his excessive load of fat had an operation performed by a physician from Northern Italy. How successful the operation was, is not re-

\*Read before the Symposium Society of Los Angeles

ported, but unfortunately for the Prince it caused his death.

Justice Von Liebig in the 19th century was one of the first to throw any light on the subject and was followed shortly by Harvey and Banting. Lately Oertel, Ebstein, and Von Noorden have been our most conspicuous contributors.

**ETIOLOGY.**—The true cause of obesity must be said to be very much in the dark, for while we know that many conditions will increase the tendency to fat production we also know that often when none of these conditions are apparently present persons may become distinctly obese, and vice-versa; in other words, something which I do not know what to call except individual peculiarity seems at times to be the most important, if not the only factor present. In most cases, however, there are certain factors present which we may call predisposing causes; of these heredity heads the list. Heredity is estimated by different authors as being a prime factor in from fifty to seventy per cent of all cases of obesity, and it is probably a hidden factor in many others.

Whether or no in these cases this tendency to obesity is due to an over production of embryologic adipose tissue or to a peculiar predisposition of the connective tissue to take on the adipose form is not decided. Suffice to say, that no matter how we may try to explain the heredity factor in obesity, the fact remains that a large percentage of obese persons show this to be almost the only cause present.

**AGE.**—Men who have passed middle age, who are between forty and fifty naturally lay on fat, and where indiscretions as regard to diet and other modes of living have been the custom in previous years, the degree of obesity may become extreme.

Girls at puberty are liable to lay on fat, and as regards sex, women are more prone to obesity than men.

Another factor that plays an important part in the etiology of obesity, is

temperament. The phlegmatic, torpid person who takes life as easy as possible, spends a long time at his meals, allows nothing to worry him, sleeps soundly and long, would naturally be more inclined to grow fat. On the other hand it is a fact that many of our most brilliant and active men are those that could easily qualify for membership in the fat class.

Other factors that seem to be influential in increasing the amount of fat are castration, impotence, and menopause.

What relation the physiologic activity of the sexual organs hold to fat production I will not take time to discuss, suffice to say that those in whom have occurred a cessation of this function whether artificial or normal are very often prone to obesity. The tendency of many women to obesity after the cessation of menstruation is an example.

In regard to the relation of nourishment and obesity; it varies considerably depending upon first, individual idiosyncrasy, and second as to the presence of one or more of the preceding causes. A general diet, rich in all ingredients, together with large supplies of liquids, especially beer and light wines, is no doubt more apt to produce fat than one poor or lacking in any of them, especially is this true if the amount of fats be in excess of the albuminates and carbohydrates. By this remark I do not mean to infer that fats are the only foods that tend to the production of adipose tissue. Fats and carbohydrates are probably entirely oxidized in the body, forming CO<sub>2</sub> gas and water. But when these are in excess the albuminates do not become sufficiently oxidized, and are partly stored up in the body as fat.

**SYMPTOMS AND PATHOLOGY.**—As to symptoms and pathology, allow me to emphasize one or two points that should be considered when one attempts to treat cases of obesity.

When obesity is marked not only is the fat increased in those tissues that normally contain fat, but it is also found



in tissue that normally is free from it. It thus not only is found in increased quantities, in the subcutaneous tissue, peritoneum, pericardium, etc., but it is also found infiltrating the muscle tissues, the muscular walls of the heart, and even in the intima and media of the blood vessels. This later condition being often complicated by arterio-scleroses puts the circulatory system on a rather poor basis, and is often found in cases of obesity where we have emphysema and asthma.

Another fact to be remembered is that we have two distinct types of obesity, the plethoric and the anaemic, this later form is often present in persons afflicted with chronic diseases as in incipient tuberculosis, and would of course compel an entirely different procedure in its management.

**TREATMENT.**—When I undertook to write this paper I wished that I could have been able to come before you with a new and better line of treatment than the old. As a matter of fact, I have nothing new to offer. The only treatment that can be expected to accomplish anything is the so-called reduction treatment, consisting in a reduction of the amount of food ingested, together with a regulation in the mode of living. In considering this mode of treatment of obesity one is compelled to generalize, as it would be folly to attempt to lay down a certain diet, consisting of a definite amount of grams of fats, carbohydrates and albuminates, or a particular amount of physical exercise, etc., that could be applied to every case. One can only at best set certain rules to be followed, and these must be modified according to the individual and the presence or absence of any predisposing causes.

Every text book contains certain diets, but these can only be considered as examples of a certain rule, which in short is as follows:

First. The reduction of all constituents in the food, the fats and carbo-

hydrates being reduced to a far greater extent than the albuminates.

Second. The restriction of the intake of liquids, especially allowing but little to be taken with the meal.

Third. The complete restriction of all alcoholics.

As to regulating the mode of living, physical exercise should be increased, cold baths be taken, and indiscretions of any kind be corrected. The exercise that gives the best result is of the kind that can be made to extend over many hours during each day, such as walking, and mountain climbing. Horse back riding is of no benefit. A half hour of hard work in a gymnasium, with the rest of the day spent in leisure is also usually of no avail, but this combined with other exercises, as mountain climbing or long walks is often very beneficial. This combination of restriction in diet, together with other things that increase oxidization, constituting the so-called reduction cures can usually be best applied in a sanitarium where the person is under personal observation at all times. But where a sanitarium is out of the question we should impress the patient with the necessity of patience and perseverance. Two points should be kept in mind—one, that these reduction cures are not weakening cures and should not be carried to the extent where they become so, and second that it is of no use to apply them one month in the year and allow the patient to live on without any restriction the other eleven months.

As to what class of patients is best suited for this kind of treatment, there is no doubt but what it is indicated in most of those that come to us—that is the persons having moderate or advanced degrees of obesity, who are between the ages of 40 and 60 years and have no circulatory disturbances. In all these cases the so-called intermittent reduction cures are greatly advocated by Von Noorden, by this method the habits of the patients are so regulated

that no further increase of obesity is allowed and at regular intervals the restrictions are increased so that a loss of from five to fifteen pounds is accomplished within a period of several (about seven) weeks, when the patient is again put back on the first regulation. This is continued until the weight is reduced sufficiently. The advantage of such a procedure will appear to all. We not only avoid as much as possible the discomfort of rapid reduction but also are enabled to get our patient under the control so necessary to the success of this treatment. In hereditary cases where obesity begins early we should not make too vicious an attempt to reduce the weight, but should rather be content with a regulation that prevents a further increase in weight and should impress upon our patient the necessity of continuing such regulations for years. Where, however, the degree of obesity in these cases are extreme, we should attempt to cause some reduction. The necessity for reducing weight in cases where kidney, heart or any circulatory disease is present is apparent when we consider the weakening effect obesity has upon these organs and also the extra amount of work put upon them by this increase and infiltration of adipose tissue. Here we should attempt reductions even if a degree of obesity is but slight. The intermittant method where one can watch carefully the effect of the treatment is here indicated. People of old age, that is beyond sixty are not as a rule fit subjects for reduction cures, as here methods of this nature are inclined to become weakening cures. As to the anemic form if not accompanied by any serious chronic diseases we should increase the albumen constituents of the food, decrease fat and carbohydrates, give tonics, as iron, plenty of fresh air, and exercise in the open to suit the case. We should bear in mind that in these cases the obesity is due to an impoverished condition of the blood which does not allow of suffi-

cient oxidization and should attempt to correct this condition before trying to reduce the weight. When this form of obesity exists together with some constitutional disease as tuberculosis, reduction cures are of course not indicated.

As to medicines in obesity, little will be said. Thyroid extract has been used with success in some cases, especially in those where the increase in flesh has been sudden and has come on without any apparent cause; also in women, after menopause it sometimes seems to work well. It has in some cases reduced the obesity to a marked degree, but at the same time produced untoward symptoms so that where one attempts to use this drug it would be well to start in small doses and increase slowly watching the effect closely. Iodoform is of benefit but may cause anaemia. Iodol has been given in two grain doses with satisfactory results. Alkalies as alkaline mineral waters, together with the other dietary treatment is of benefit. Fucus vesiculosis in the form of an extract has been highly recommended. It is sold on the market as Anti-fat. Phytolacca, or the resinoid preparation, phytoliene in ten m. doses six times a day has been used extensively.

In conclusion I wish to emphasize the fact that to give any medicine and to disregard the diet and other modes of living is simply ridiculous. Medicines at best must only be considered as secondary measures.

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DR. F. S. MASON, OF ENGLAND, writing in *La Tribune Medicale*, says the strontium salts are preferred by progressive physicians because they do not depress patients as do the potassium or ammonium salts. Strontium salts are to a great extent intestinal antiseptics, preventing secondary fermentation, and insuring better assimilation of nourishment. This is especially marked in the case of the iodide where large doses are required for antisyphilitic treatment during a long period.

## MASTOIDITIS—SOME PRACTICAL POINTS.\*

HILL HASTINGS, M. D., LOS ANGELES.

I very greatly appreciate the honor of the invitation to contribute something to the interest of this meeting. The pleasure of accepting this invitation is somewhat tempered by a feeling of regret that this paper is not more worthy. I would like to be able to present some of the practical points that have stood out plainly in my experience in mastoid work, especially as to the indications for operation. Therefore the personal element must enter into this paper, and if overmuch, it is because of the desire to state facts and conclusions coming within my own observation.

Mastoiditis, like appendicitis, is a new disease, in the sense that thirty or forty years ago cases of mastoiditis were not diagnosed, nor were cases of appendicitis. The mortality tables are nevertheless full of records of deaths from so-called "brain fever," and "inflammation of the bowels," a large proportion unquestionably being due to mastoiditis and appendicitis. The diagnostic ability of the medical profession was keen at that time, but had not been directed along these special lines. When it came about that quick and accurate diagnoses were made, operations for appendicitis were urged that would never have been considered by the older members of the profession to have been indicated. The result was twofold. First, and most beneficial, the saving of many lives by early operations, and, second, the performance of some useless operations, which really follows as a corollary to the first.

The same can be said of mastoiditis. The mortality has been greatly reduced through urging operation before serious complications arise. Also, which should be confessed, some useless operations have been performed, inasmuch

as some cases of mastoiditis would have gotten well without operation.

It is apparent that in this rather general summing up of the past experience in these two diseases, the value of the operative technique has not been considered. Its importance no one can minimize. However, if fair operative experience is granted, I believe the mortality from mastoiditis, like that from appendicitis, is dependent more on good judgment as to the proper time to operate than on very great operative skill.

The question of the saving of lives from mastoiditis, as well as the prevention of unnecessary operations, hangs, then, on the development of conservative and safe diagnostic ability. I believe that the use of the term "conservative" may be perverted, and when so perverted, conservatism is by no means safe.

When one considers that the brain and the lateral sinus are separated by a hard, bony plate from the mastoid cells, it would seem that the two most frequent and fatal complications of mastoiditis (meningitis and sinus-thrombosis) would seldom arise. And yet it is surprising in how large a proportion of cases erosion of the inner bony table is found to have occurred, with purulent granulations or fluid pus on the cerebral dura and sinus. When care is exercised that operation be not postponed beyond the limit of safety, it is not too much to expect that we will see few cases with serious complications.

What, then, are the safe indications for the mastoid operation? Mastoid swelling, excessive tenderness, high fever or chills, rarely occur in adults. It cannot be too strongly urged that to wait for these indications means taking grave and unwarrantable risk of sacri-

\*Read before the Pasadena Medical Society, April 25, 1906.



ficing the life of the patient. Unfortunately, heat, redness, pain and swelling are the signs accepted by the laity as diagnostic of pus formation. Few patients would, therefore, accept timely operation unless urged by their family physician, or unless it happened that a fatal case had in his knowledge resulted from postponement.

Excluding then, these signs, what safe indications have we for operation? After taking two or three hundred histories of mastoid cases, prior to operation, a set of symptoms and signs will be found that is sufficiently regular to be accepted as a safe guide for one's judgment. There will, of course, be exceptions where far more extensive destruction has occurred than the symptoms and signs indicate; and also exceptions where a cure might have occurred without operation. These exceptional cases, on the border line between a rapid recovery or as rapid a fatal termination, serve but to prove the safe rule and to make us respect the value of consultation. This set, or syndrome of signs and symptoms, referred to as a basis for urging operation, may be enumerated as follows:

1. A history of the recent occurrence of a severe earache, accompanied by deafness (the watch as a rule not heard on contact); throbbing, bubbling or machinery-like noises in the ear.

2. A purulent discharge that shows no signs of decreasing. As a rule, on the appearance of the discharge, much of the pain in the ear subsides.

3. Mastoid tenderness, which is usually not severe, and may be found only on deep pressure over the antrum and the tip. The persistence of moderate tenderness over the whole mastoid is a far more dangerous sign than is the severe tenderness found during the first day or two of the disease. The latter may be due to great congestion of the mastoid cells, and may disappear rapidly on securing good drainage through

the drum membrane of the pent-up middle-ear secretion.

4. The physical signs of a severe infective inflammation of the middle ear, found on careful examination of the drum membrane, namely, a beefy-red, bulging membrane, usually with an insufficient perforation, and accompanied by sagging of the adjacent postero-superior canal wall. This picture of the ear-fundus, as it were, is typical and vastly different from that of an acute catarrhal inflammation of the middle ear, where from pressure of the exudate there may be as severe an earache.

Of these four indications the third and fourth are the most important, namely, the physical signs found on inspection of the drum membrane of violent inflammation of the middle ear; and the persistence of mastoid tenderness. Fever, which is usually present, is of low grade and of no special significance, nor is there much prostration. In fact, the patient is usually out of bed and may be attending to his duties. Nevertheless, the above enumerated signs and symptoms when present after five to ten days from the onset of the earache indicate a mastoid operation. The time limit varies somewhat with the individual case, and with the appearance of other symptoms such as very acute mastoid pain, high fever, and prostration. Also varies with the nature of the infection, determined by microscopical examination of the middle ear discharge. The quantity of discharge is another factor for consideration.

The important point that I desire to make is that there is no one symptom, but a syndrome of fairly constant signs and symptoms, indicative of operation, among which mastoid swelling and redness must not be expected, at least in adults.

These observations may seem trite to many of you, and some of the conclu-

sions may be unacceptable. Individual opinions, of course, differ. These expressed are, however, founded on a careful study of over 500 mastoid cases before and after operation, the individual records of which I made, and the operative findings in 324 cases which I have had the privilege of observing, either as assistant or as operator. Of these, 281 were operations during a year's service at the New York Eye and Ear Infirmary; 17 died, a mortality of 6.5 per cent. This is low, considering that several almost inoperable cases were admitted. Of the remainder, 43 cases, occurring here in Southern California, 4 died. At least two of these would have been saved by an earlier

operation. One of the two had been advised, but refused operation, and when medical attention was called, active meningitis had set in, and operation was not considered advisable. Taken in time, I am inclined to believe that the mortality from mastoiditis should not be over 1 per cent., if that much.

In conclusion I desire to express the belief that there will be in the future more timely operations and fewer needless operations when the general practitioner will give to the study of the diagnosis of mastoiditis and the operative indications the same searching investigation that he is now devoting to other surgical subjects.

Delta Building

## MESSAGE—A CHANGE NEEDED IN OUR ATTITUDE TOWARDS ITS PRACTICE.

BY JOHN T. RANKIN, M. D., LOS ANGELES, CAL.

Among physicians who are interested in the use of massage as a therapeutic aid, and who appreciate the method at its full value, there is a feeling of regret concerning the haphazard and desultory manner in which the treatment is carried out by the nurse, masseur or lay assistant. Too little attention is given the study of manual methods of treatment in most of our American medical schools, not because the profession do not believe in and use massage, but because we have learned to depend upon laymen for its application. Herein lies our mistake. The pupil may be informed by text book or teacher that, in certain diseases, "massage is at times useful," or "massage may be tried," as though it were indeed a very doubtful expedient. It is not to be wondered at that his faith in the efficacy of massage should be greatly shattered by such mention of it, and too often it acts as the "faint praise which damns." We can not be surprised there-

fore that when the student leaves his alma mater his conception of massage is as superficial as are the manipulations of the nurse, whom he instructs to "try massage," in the case under his care, "as it is pleasant and may have a soporific effect." Experience will correct these superficial ideas, but why not let this come during college life instead of afterward?

There are few laymen indeed who are competent to give massage treatment when such treatment is aimed at something more than a mere soothing action. Massage does have a definite and marked effect upon practically all physiological processes, and when pathological conditions intervene, it may often be used with marked success to assist in the restoration or amelioration of such conditions. Failure to obtain beneficial results from massage may arise from having depended for its administration upon those who were not competent to give the treatment in a man-

ner calculated to produce the most efficacious results. Such incompetency may be due to ignorance of anatomy and physiology, to a lack of knowledge regarding pathological conditions, to inefficient training and absence of practical experience, or, in females, to inadequate physical strength. It is my belief that the great majority of masseurs are lacking in one or all of these particulars. Yet seldom do we see one who does not claim proficiency in the art, and they may be honest in their claims simply because of their limited vision concerning the breadth and possibilities of the system. Because they have "rubbed" patients for this, that and the other trouble, the art is mastered and they are experts in the work. Little wonder that the physician at times loses confidence in the value of the method when its application is so frequently entrusted to those unfit to use it.

A person's conception of the value of a method is so frequently derived from his observations as to its workings in the hands of others, and when such observations are made under circumstances of fairness to the method under investigation the conclusion must bear weight, but when the test is made by incompetent exponents, the observer should temper his judgment accordingly. The use of massage is so universal that we have come to regard its application as extremely simple and capable of proper administration by anyone who can pronounce the word with a foreign accent.

It is true that there is nothing difficult or complicated about the administration of commercial massage as doled out to weary travelers at the various barber shops, hotels, bath houses, massage and toilet parlors, in the same routine manner as does the barber who shampoos in like fashion every head presented.

Stereotyped massage movements are

characteristic of the great majority of masseurs whether nurse, professional or bath-house assistant—certain movements which they have been taught are followed with routine precision in every case, without thought of special adaptation of the treatment to varying conditions. Now, this may be very well in ordinary commercial massage, which is measured out to customers like automobiles, at so much an hour; but when the physician has a patient suffering from known pathological conditions, and desires the action of massage upon these conditions, he should wish that treatment administered not as a luxury, nor as a rule-of-thumb method, but as a therapeutic agent directed with some definite idea to the case at hand.

He should wish the dose of massage given by one possessing as much professional knowledge of the disease as of the remedy. Knowledge of circulatory anatomy, physiology, symptomatology and pathology should be insisted upon as a pre-requisite to circulatory therapeutics, whether the agent used be chemical or physical, *and so it should be with disorders of any bodily structure.*

The pharmacist's knowledge of drugs does not make him competent to administer his drugs for diseased states, neither does the masseur's knowledge of massage render him most capable for the administration of massage in diseased conditions. Each may know considerable concerning the remedy, but the chances are that neither knows anything reliable concerning the disease for which they may administer their remedy. The day will come when the medical profession will no more think of referring patients to masseurs for *specific* manual treatment than we do now of sending our cases to the druggist for treatment after having labeled them with the names of the diseases from which they are suffering.

The history of almost every branch



of medicine shows that so long as such branch was allowed to remain in the hands of laymen its progress was deterred, its practice empirical, its ethics lowered and naturally its results impaired. But when these things are placed in the hands of medical men what a change is noted. Progress is certain to take place, empiricism is thrown aside, ethical principles are installed and successful results gladden the heart of physician and patient.

The present chaotic state of manual therapy may be lifted from this position as have other branches of the medical art, literally, by the hands of the medical profession. Changes come slowly in the medical guild. It is a conservative body. Certain customs have become established by transmission from practitioners of one decade to those of another. We have been adhering to certain manners of procedure because our forefathers did so. In most instances these customs come to us as something which should be continued and observed as did those before us.

On the other hand, there are customs which for our common good, should undergo a change. Prominent in this list stands the practice of therapeutic massage. Its place and practice should be within the regular fold by virtue of ancient discovery and usage, and to replace and hold it in its proper position should be the desire of all physicians who possess the ethical sense. Although, as stated, changes in our profession do not occur rapidly, still I feel confident that the time is not far distant when we will come to look upon therapeutic massage as a method of treatment which should be administered only by qualified medical men.

The majority of the older practitioners naturally will not care to change their fixed habits of procedure along this line, so through the younger members of the profession and those who, within the next ten years, will enter our ranks, must this change come.

If we believe that the confines of regular medicine are the proper field for *every measure* relating to the diagnosis and treatment of disease, we must be interested in some plan which will quickly and securely place therapeutic massage therein. Such a plan and the one which would seem most likely to fulfill its requirements would be for our colleges to establish a chair of manual therapy, giving a thorough course of didactic instruction to cover the subject, together with practical clinical application of therapeutic massage in the various disorders wherein it is indicated. In this way the student would become proficient in the use of the manual methods of treatment. Personal administration would become a fixed habit with him, and in a comparatively few years these methods would be firmly placed where they belong.

In the meantime there is an urgent need, in nearly every city of our land, of reputable medical men who will take up this work, giving particular attention to it, with the idea in view of co-operating with and helping their medical brethren who have not the time to personally utilize the manual methods of treatment. Some of our larger cities already have men who are working along this line, notably Dr. Douglas Graham of Boston, and Dr. Gustave Norstrom of New York, both men having more than a national reputation in this branch of work.

The situation which confronts the profession today is this: When the physician has a patient requesting and in need of manual therapy, if he does not administer such treatment himself, he must either send this patient to one outside of our ranks, a layman, or the patient will seek the services of an irregular. He would certainly dislike to see the latter occurrence, and there are many good reasons why he should hesitate to pursue the plan of sending the patient to an outsider.

If in all our cities there were competent medical men who would give their time to this work they would find that the profession would support them as soon as they had proved that they were deserving of support, and on the other hand, the profession would soon learn to appreciate the opportunity of placing their patients in the care of worthy colleagues for this particular treatment. Could we not expect better results to all concerned if this plan were carried out?

If it is argued or admitted that laymen can administer therapeutic massage as successfully as can the physician, then

we weaken the science and art, as well as the nobility and dignity, of our calling along other therapeutic lines as well. We cannot claim superior ability in therapeutics and admit inefficiency in any branch thereof. Surely the laity are prolific enough in their charlatanic schemes and misuse of various methods of treatment without our deliberately continuing to place the opportunity for such practice in their hands. Would it not be wise for us to consider a change in our position relative to the practice of therapeutic massage?

Union Trust Building.

## DEPARTMENTAL

### DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTENGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

**INFECTION IN TUBERCULOSIS.**—A very interesting review dealing with the subject of "Infection in Tuberculosis" appears in the *Berliner Klinische Wochenschrift*, Number 23, 1906. Schlossmann of Dresden, in support of the theory that tubercle bacilli enter the body through the alimentary canal, says, "that in spite of the most careful search, tubercle bacilli have never been found in the larynx or in the large bronchi;" therefore he does not believe that infection of the lungs takes place through inhalation, but through the alimentary canal, the bacilli passing through the lymph stream to distant parts of the body. In this alimentary infection, however, not only the intestines, but the entire alimentary canal takes part.

In the Foundling Asylum of Dresden, Benswanger reports that of 532 sections, 36 cases of tuberculosis were found among children of the first year of life, making 6.8 per cent. In the second year the mortality reached 42 per cent.

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**TUBERCULIN TEST.**—The same author

reports upon the tuberculin test which was given to children. He believes that in children the positive reaction to tuberculin test is of much more importance than in grown people, because in children we do not find latent areas which might react. Every child who reacted positively during the first six months of life died of tuberculosis.

Benswanger is a strong advocate of the tuberculin test. He has made thousands of injections without noticing a single bad result. He found in 261 children, positive reaction in 35; 42 came to post-mortem, and of these 16 had shown a positive reaction, and 26 a negative. The 16 that had reacted positively showed general tuberculosis, while of the 26 that did not react, 25 were free from tuberculosis. Of those that reacted positively which have not yet come to post-mortem, 7 had already shown signs of tuberculosis; of the 12 remaining that had reacted positively, there are no signs as yet of tuberculosis being present. Of the 190 cases which did not react to tuberculin, one case was shown to be

tubercular. This does not only show the value of the tuberculin test and its reliability, but at the same time shows its harmlessness when given intelligently. The tuberculin test should be employed more and more in the diagnosis of tuberculosis by those who are not sufficiently sure of the diagnosis as made by physical examination.

The writer has given the tuberculin test many times, and in only one case which failed to react has tuberculosis developed afterwards. In this case the fault was most likely due to the fact that the tuberculin was old and not reliable. With a freshly prepared solution of a reliable tuberculin, and an intelligent administration of the dose, there can be no harm done, and many patients can be put under treatment at an early and favorable time for recovery.

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ADMINISTRATIVE CONTROL OF PULMONARY PHTHISIS.—The local Government Board of Scotland recently issued a very important memorandum on the "Administrative Control of Pulmonary Phthisis." (*Tuberculosis*, May, 1906). The first section deals with tuberculosis as an infectious disease. It takes up the method in which tuberculosis is spread, and deals especially with the scattering of infection by sputum and by what is known as the "droplet infection" of Flugge. In recent years certain observers have been inclined to teach that more cases of tuberculosis developed through droplets from coughing, sneezing and talking than by the bacilli which come from expectoration. Many very able men have given this theory credence. While we do not doubt that bacilli can be thrown out in this fine spray, yet it seems absurd to claim that it is the chief cause of the spread of infection, when we know that there are millions and millions of bacilli thrown out daily in expectoration which dries and passes into the air as dust, to be inhaled.

We have heard teachers in tuberculosis

say that "the tuberculous patient is a great menace, no matter if he does destroy his expectoration, because he is constantly throwing out this fine spray, which covers his clothing and his bedding, and thus renders them dangerous." We believe that such an attitude is not only wrong, but we believe it is an injustice to the tuberculous patient, and that it is making mountains out of mole hills.

It is generally conceded by the best authorities today that if a tuberculous patient will carefully and conscientiously take care of his expectoration, he is not a dangerous individual with whom to associate and live. To quote from the above article:

"That tuberculosis is handed on from one case to another is now a generally accepted fact, and that the tubercle bacillus is frequently to be found in the dust of rooms which have been occupied by a consumptive patient careless as to the disposal of his expectoration is well established. But we are not prepared to accept the unqualified statement in the report that 'by the act of coughing or sneezing the virulent material is showered or sprayed to a considerable distance.' This is a conclusion which we consider has not been 'completely established,' either 'by observation or experiment.' If it were true, a ward of consumptive patients would be a hotbed of infection. To show that authorities are not agreed as to so-called spray infection, we may quote Professor Cornet's remarks on this very subject. He says, 'The recent assertion of Flugge that infection is brought about by the minute particles of sputum thrown out by coughing is open to a number of objections. Very slight importance need be attached to the particles of sputum thrown out by coughing, since the bacilli contained are but a very minute fraction of the number which are cast off in the bulk of the sputum, and permitted to dry. Moreover, these particles are for the most part not sputum at all, but sterile



saliva, as I demonstrated in a series of experiments. The best proof that infection by droplets plays a role of no importance is the fact that I have never been able to discover tubercle bacilli on the walls, or otherwise distributed, in the case of consumptive invalids who were careful with their sputum, in spite of the fact that there was ample opportunity for the dissemination of droplets. On the other hand, the results were always positive in cases in which the patients permitted their sputum to dry. A recent research of B. Frankel's demonstrates that the dissemination of bacilli by coughing is insignificant in comparison with the number liberated by the drying of sputum. He let a number of consumptive patients wear masks for twenty-four hours at a time, and with 219 of these masks he caught 2600 tubercle bacilli in 32 days. Heller reckons 300,000,000 germs to a single pellet of sputum, or 7,200,000,000 a day, if the patient expectorates not more than once an hour. On the hand, we have a number of consumptive patients thirty-two days, and 2000 bacilli possibly let out into the air; on the other, one consumptive patient a single day, and 7,200,000,000 bacilli in the sputum, i. e., more than 2,000,000 times as many."

We consider this a matter of great importance. If the public once gets it into its head that a person who coughs or sneezes is showering or spraying virulent material about him to a considerable distance, consumptive persons, without any discrimination as to the stage of the disease, will straightway be treated as lepers. To our knowledge, grave injustice is already being done in individual cases. We know of one patient who has never had any bacilli in his sputum, who has been dismissed from his post and ordered to quit the neighborhood, although in perfect health, because he was under suspicion of being dangerous to others.

**HOT POULTICES FOR PAIN IN PNEUMONIA INSTEAD OF AN OPIATE.**—With two pounds of fresh linseed meal, that contains twenty-five per cent of oil, and with boiling water make a poultice large enough to cover much more than the area involved in the inflammation, and apply it as hot as it can be borne, and then apply over the poultice a vessel warmer, curved to fit, containing a sufficient quantity of hot water to keep the poultice continually a high temperature, renewing the hot water every hour; the patient will be kept free from pain without the aid of an opiate. If poultices are allowed to become cold and clammy, and an hour or two later replaced by fresh ones, which alternately produce a hot and chilled surface, harm instead of benefit results.

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DR. J. R. EASTMAN, professor of surgery in Central College of Physicians and Surgeons, of Indianapolis, says that a commencing felon will always be aborted by the local application of alcohol under perfect air exclusion. Cotton is saturated with alcohol, and placed about the affected part and a thin rubber finger-stall applied over all. Seventy-two hours usually suffices to give relief or even effect a cure. He learned this in Von Bergmann's polyclinic, in 1897, since which time he has not had occasion to lance a single felon, the treatment of which was begun in time by this method.

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**A VALUABLE ADJUVANT** to drug medication in the treatment of hemoptysis is circular constriction of the limbs by bandages, loose enough to permit the influx of arterial blood, yet sufficiently tight to prevent the venous return. By thus holding the blood in the limbs we reduce blood pressure.

# SOUTHERN CALIFORNIA PRACTITIONER.

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.  
DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.  
DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

Address all communications and Manuscripts to

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## EDITORIAL.

### URIC ACID AND THE PURIN BODIES.\*

Perhaps in no medical subject have imaginative speculation and faultily conducted experimentation played so prominent a role as in the question of uric acid. However, during recent years through careful investigation with accurate methods, our knowledge of uric acid, the purin bodies, their origin, the formation of uric acid in the animal organism and its destruction, have been considerably extended, and we agree with Dr. McCrudden that the time is ripe for a compilation of these researches. An English compilation of these scattered and rather inaccessible investigations is particularly welcome at this time, especially for the reason that general opinion in the English-speaking world has been and is unduly influenced by the poetry and imaginative romanti-

cism of a certain English writer on this subject.

Dr. McCrudden has arranged his compilation into three divisions—Chemistry, Physiology and Pathology. The treatment of each division is prefaced by an historical survey. This adds much to the value of the work. An excellent bibliography is appended. This bibliography, while not complete, contains references to most of the researches deserving attention, and constitutes one of the most valuable features of this book. At the completion of each topic a summary is added. In the majority of instances these summaries are helpful, but in some cases, particularly the Formation of Endogenous Uric Acid, and the Destruction of Uric Acid, these summaries are deficient and do not give an accurate survey of the subject matter.

\*The Chemistry, Physiology and Pathology of Uric Acid and the Physiologically Important Purin Bodies, with a Discussion of the Metabolism in Gout. By Francis H. McCrudden. P. B. Hoeber, 69 E. 29th st., New York 308. pages, canvas \$3.00; paper \$2.50.

**CHEMISTRY.** Without an adequate knowledge of the chemistry of uric acid, the related purin bodies and antecedent substances, a comprehensive understanding of the physiology and pathology of uric acid scarcely is possible. In this chapter the constitution of related bodies, their chemical properties, means of synthesis, methods of determination and solubility are discussed in so clear a manner that no physician should experience difficulty in following the text. Emphasis is laid upon the well-known fact that acidity and alkalinity cannot be estimated accurately by titration methods. Physical chemistry, the determination of the sum of hydrogen ions and hydroxyl ions respectively, gives exact results, and according to physical chemistry, blood is absolutely neutral. Further, Klemperer has shown that in gout the alkalinity by titration methods is not decreased, and that blood in gout is not saturated with uric acid, and that such blood can dissolve as much uric acid as normal blood. Probably uric acid occurs in gouty blood as acid sodium urate, and the solubility of this form of uric acid would not be increased by increasing the titration alkalinity of the blood. And further, if it did increase the solubility, what proof have we that the administration of acid or alkali increases the acidity or the alkalinity of the blood? Absolutely no evidence. The conclusion is clear that there is no scientific basis for alkali therapeutics in gout.

**PHYSIOLOGY.** All students of metabolism long have recognized the twofold origin of uric acid, the exogenous and the endogenous. Since Burian showed

that the only source of the exogenous uric acid is the purin substances of the food ingested, interest has turned to a study of the endogenous uric acid. The nucleoproteids of the tissue cells and leucocytes were looked upon as the sources of endogenous uric acid until Burian brought forth evidence that the greater part of the endogenous uric acid comes from the purin base xanthin, resulting continuously as a metabolic product of living muscle tissue.

In view of the fact that in birds uric acid is of synthetic and oxidative origin, it has long been held that in mammalia uric acid may be the result of synthetic processes. This subject is covered clearly, and the experiments are cited which show that on a purin free diet there is no cleavage product which is able to be built up into uric acid.

In regard to the destruction of uric acid in the animal organism there could be improvement in the treatment of the subject-matter. That a quantity of uric acid can be introduced into a mammal and only part recovered should be a well-known fact. The evidence of this fact is made more convincing by the studies on various isolated organs in which this destruction has been investigated directly. When blood to which uric acid has been added is perfused through a surviving liver a marked progressive decrease in the uric acid is observed. The recognition of this fact—that the organism is able to break up uric acid has changed profoundly our attitude toward the subject of purin metabolism. Shittenhelm has shown that the kidney possesses this ability to a noticeable extent, and also the marrow. The author, Dr.



McCrudden, does not seem to make clear the significance of this fact, or appreciate its far-reaching importance. The role of intracellular enzymes in every feature of metabolism is, beyond conjecture. It is not exaggeration to say these enzymes play a preponderating part in purin metabolism.

**PATHOLOGY.** Attention is directed to the finding of uric acid in blood in other than rheumatic diseases, and to the fact that in gout the excretion of uric acid is not decreased. Moreover, the ratio between purin bases and uric acid in gout is not abnormal. One of the favorite theories in the etiology of gout—that there is a temporary renal deficiency, a failure to excrete the uric acid and other substances—is not supported by evidence. Again, there is no evidence that necrosis precedes the formation of urate concretions. The deposits in gout are not uric acid, but sodium acid urate, and further, these concretions are not deposited from saturater solutions. The injection of uric acid in normal animals does not lead necessarily to toxic symptoms. There are data to support the belief that uric acid is not the main etiological factor in rheumatic diseases. In these diseases there is perverted proteid catabolism. There are alternate periods of nitrogen retention and loss without corresponding changes in body weight. Recent investigation leads to the belief that rheumatic diseases are diseases of proteid catabolism, and that the presence of uric acid in the blood is more of a symptom than an etiological factor.

STOOKEY.

# DR. S. A. KNOPF.

The current issue presents as a frontispiece a halftone of Dr. S. A. Knopf, and prints also an abstract of his remarks before the recent meeting of the Los Angeles County Medical Association on "The Early Diagnosis and the Prognosis of Pulmonary Tuberculosis."

There are a number of reasons why Southern Californians should take a real pride in Dr. Knopf. It was he who had the honor of being the first student to matriculate at the College of Medicine of the University of Southern California, when it was established twenty-one years ago, and it was in the **SOUTHERN CALIFORNIA PRACTITIONER** of October, 1886, while he was still a freshman, that there appeared from the pen of Dr. Knopf—who has in late years probably contributed more writings on the sociological phase of the antituberculosis crusade than any other American—what was probably his first contribution to the medical press.

To Dr. Knopf belongs the distinction also of having been, in his youth, the first night nurse at the Los Angeles County Hospital, where he served also as the first interne. And his residence in Los Angeles as a physician in private practice with Doctor Nadeau, and his work at the County Hospital played a very large part in leading him into the study of tuberculosis as a specialty.

He subsequently took post-graduate work at Bellevue in New York and graduated with honors from the University of Paris. In Germany he became an assistant at the Falkenstein Sanatorium to Dr. Philip Dettweiler, who, with his own chief, Herman Breh-

mer of Goerbersdorf, shares the honor of being one of the fathers of the sanatorium, i. e., the open-air treatment of pulmonary tuberculosis.

Elsewhere in this issue of the *PRACTITIONER*, in the "Twenty-one Years Ago" column, is printed the letter which Dr. Knopf sent to the *PRACTITIONER* in 1886. The spirit and the motive of that communication—a love of one's fellows and a desire to see justice done where justice is due—this spirit has only increased with years in Dr. Knopf, and has made him a staunch and powerful advocate of the rights of the overworked, over-crowded and underfed poor, whose unending ranks are being constantly decimated by the great white plague, a plague that has its being because of man's ruthless disregard of his fellows and indifference to hygienic modes of living.

It has been a real pleasure to welcome Dr. Knopf back to Los Angeles. His sojourn among us has been productive of great good. May he return often and be with us long.

#### THE BARLOW MEDICAL LIBRARY.

There is nearing completion in Los Angeles, the building for an institution which should do wonders in promoting scientific development and in elevating the tone of the profession of Southern California and the Southwest. This Building, to which we refer, is that of the Barlow Medical Library, situated on Buena Vista street, opposite the buildings of the College of Medicine of the University of Southern California.

The structure, which is of a handsome, dignified, classical type, built entirely of reinforced concrete and abso-

lutely fireproof, seems admirably adapted in its interior arrangements for the noble work to which it will be consecrated.

Besides the circular dome-covered reading hall, in which the book stacks will be placed, and the usual office and coat rooms, there will be several chambers in which members doing research or other work may leave their books and papers, knowing they will be undisturbed until their return. In this way the absolute quiet and the absence of interruption so necessary to thorough study and investigation will be attained.

The institution will start with the excellent library of the College of Medicine of the University of Southern California, consisting of six thousand or more volumes, which Dr. Stanley Black has been especially instrumental in collecting and preserving. In this collection are fairly complete files of many of the medical journals since the seventies, and with this nucleus it will be possible to begin practical library work at once. The fact that this is an absolutely fire-proof building should make it possible also to obtain loans of books from other medical libraries, and in this manner the number of accessible books would be vastly increased.

The title to the property, which has cost some twenty-five thousand dollars with its improvements, Dr. W. Jarvis Barlow will turn over to the College of Medicine of the University of Southern California. This insures that the property will be held by a responsible corporation, whose own vested interests

will be greatly benefited by the careful administration of the library trust.

The active control of the library itself, so far as a governing board and the election of a librarian and assistants are concerned, it is contemplated to place entirely in the hands of the medical profession of Southern California and the Southwest. While the exact plan of organization has not yet been definitely worked out, it is probable that the library will be opened to all members of the medical profession and to the students of the medical colleges, for reference use, without any charge whatsoever. The loan of books, as regards number of books and the time they may be borrowed, will be privileges granted to subscribing members.

For as yet there is no endowment, the income of which will pay the expenses of the attendants and of the purchase of new books. The money for these needs must come from membership dues, donations and so on. It is intended also to place the library's facilities at the disposal not only of Los Angeles borrowing members, but of physicians throughout the Southwest who may enroll themselves as subscribing members. There is a special low rate on the expressage of books, so that in this way the library may be an aid to the medical student and practitioner, whether he be in hamlet or city, far or near.

The committee at present in charge of the building and its equipment consists of Doctors W. Jarvis Barlow, Stanley Black and George L. Cole, and

this committee will in due time inform the profession throughout the Southwest, when they have accomplished their primary work. They will also indicate future needs. When that time comes there should be a generous response from the members of the medical profession.

It is of interest, that in a series of replies received from medical librarians throughout the country in relation to the best methods of cataloguing, of organization, and of the raising funds for maintenance, there was a general expression of gladness and congratulation at the munificence of the gift, that will take Los Angeles and Southern California out of the "no medical library" class and place it on a footing equal to that of institutions that have been in existence for a half-century or more.

If the Barlow Medical Library does anything like the excellent work accomplished by the medical libraries of Chicago, for instance, the beneficial and far-reaching influence on the medical profession of the Southwest, and the people whom they are called upon to care for in sickness and injury, will be great indeed.

That this beneficial influence will be exerted we have not the least doubt, time will amply demonstrate.

---

IN RHUS POISONING, try the following simple remedy that is said to cure every case in a short time:

R. Fl. Ext. Serpentina.....2 oz.

Sig.: Sponge parts affected well with contents and take twenty drops every four hours in water.



## EDITORIAL NOTES.

Dr. E. W. Fleming has returned from the East.

Dr. John R. Haynes is traveling in Europe.

Dr. Thaddeus Up de Graff of Pasadena is spending a year in Europe.

Japan produces annually 22,000 tons of sulphur.

Dr. V. A. Rendon of Los Angeles is traveling in Europe.

Dr. Harvey G. McNeil of Los Angeles spent his vacation at Lake Tahoe.

Dr. W. Jarvis Barlow spent his vacation in the mountains of Idyllwild.

In 1905 America shipped 2,133,973 cwt. of bacon to Great Britain.

Dr. Moir of Deming, New Mexico, is taking a post-graduate course in the hospitals of Chicago.

Dr. A. Tyroler of Los Angeles has been devoting some time to the hospitals of the East.

Dr. W. H. Fales of Clifton, Arizona, has been spending his vacation greeting friends in his old home in Los Angeles.

Dr. H. Bert Ellis of Los Angeles recently gave a delightful dinner to Dr. S. A. Knopf of New York City.

Dr. Adelbert Fenyes of Pasadena has returned after several weeks in the East and Canada.

It is reported that Dr. J. M. Crenshaw will remove from Redlands to Long Beach.

Dr. A. L. Macleish is taking his vacation tenting under the pines at Idyllwild.

Dr. O. S. Brown of Winslow, Arizona, has been spending a few weeks in Southern California.

Dr. Titian Coffey of Los Angeles has been spending a few weeks at Colorado Springs.

Dr. D. G. Moseley of Redlands has

been spending a few days in San Francisco and vicinity.

Dr. Edwin O. Palmer of Hollywood has been spending his vacation in Idyllwild.

Drs. Harry M. Sherman and George J. McChesney have opened offices at No. 2210 Jackson street, San Francisco.

Europe produces annually 80,000 tons of honey; Germany leading with 20,000 tons. Spain is second in this product.

Dr. Henry P. Newman, the Chicago surgeon, proposes to spend the ensuing winter with his family in Southern California.

"Music and Poetry: Their Relation to the Medical Life," is the attractive title of an entertaining and scholarly address by Dr. A. W. Brayton of Indianapolis.

Dr. and Mrs. W. A. Weldon of San Pedro, Cal., are on a vacation tour through Northern California, Utah and Colorado.

Dr. and Mrs. J. A. McGarry of Los Angeles recently gave a theater party in honor of Dr. and Mrs. S. A. Knopf of New York City.

Dr. Aaron B. Talbert died in Pasadena July 3rd, at the ripe age of 80 years. His body was taken to Minneapolis for interment.

Dr. A. T. Newcomb of Pasadena has returned from six weeks in the East, during which he attended the American Medical Association in Boston.

Dr. Dudley Fulton is in Vienna devoting himself closely to hospital and laboratory work. His address is IX. Kinderspitalgasse, Vienna, Austria.

In 1905 Brazil exported 5,822,000 pounds of castor seed and 46,398,000 pounds of cocoa; 10,820,000 pounds of coffee and 44,859,000 pounds of tobacco.

Dr. and Mrs. W. Jarvis Barlow of Los Angeles recently entertained Dr. and

Mrs. Philip King Brown of San Francisco.

Drs. F. T. Bicknell, Geo. W. Lasher, M. L. Moore, A. C. Rogers and Geo. L. Cole are spending their vacations in the Yellowstone Park.

Dr. Hamilton Forline, recently of Chicago, is planning to erect a great health resort in the mountains near Santa Monica, Los Angeles county.

Dr. J. F. Jones of Martinez, Arizona, is spending some time in the East. During his absence Dr. Duke Keith has charge of his practice.

The College of Dentistry of the University of Southern California has just issued its tenth annual announcement. It is a credit to the college, to the printer and to the city of Los Angeles.

The Chicago packing-house scandal has not reduced the sale of American ham and bacon, but has had a marked effect upon the sale of canned meats with "Chicago" upon the labels.

The world's wine crop for 1905 reached about four billions of gallons. France leads with 1,710,900,000 gallons, and the United States comes twelfth with 34,000,000 of gallons.

Dr. and Mrs. A. W. Vannemann of Hermosillo, State of Sonora, Mexico, have been enjoying a vacation in Los Angeles. They were the guests of Dr. and Mrs. P. C. Pahl at a dinner party recently.

Dr. Alfred B. Jordan has removed from Dale, San Bernardino county, to Spaulding Station, Los Angeles county. This is a suburb of Los Angeles, and the doctor's office is on 65th street, three doors east of the Long Beach car line.

The Health Department of Los Angeles has issued a very valuable report for the year ending November 30, 1905. Any physician can secure this by corresponding with the health officer, Dr. Powers.

Cooper Medical College, San Francisco, is out with its usual annual an-

nouncement. The little difficulty they had up there on April 18th did not feaze them for a minute, and no prospective student need stay away on account of either fire or earthquake.

Dr. and Mrs. W. W. Beckett of Los Angeles recently entertained at dinner for Dr. and Mrs. S. A. Knopf of New York City. There were twenty-four guests. Besides this being a reunion of friends, it was also the house warming of Dr. Beckett's new mansion on Harvard boulevard.

The Pottenger Sanatorium for Diseases of the Lungs and Throat, located at Monrovia, Cal., has just issued a very valuable scientific report of the results of treatment in ninety-four cases of pulmonary tuberculosis. Physicians interested should write for a copy of this monograph.

Dr. T. D. Kellogg, who had been in Southern California for the last thirty years, died on July 4th at his home in Chino, San Bernardino county, Cal. The doctor was a generous, devoted, general practitioner. He was also a botanist of considerable repute, and had more than average literary ability. He was born in Montreal, Canada, in 1845.

At last reports Dr. J. de Barth Shorb was in Berne, Switzerland. Dr. Shorb says: "I have had the privilege of seeing Kocher work. The most characteristic things I have seen here so far are thyroidectomies under cocaine anaesthesia, and excellent bone surgery. Prof. Kocher uses silk largely in his osteoplastic work. I met Dr. MacGowan in Rome."

Socorro, New Mexico, the county seat of Socorro county, seventy-five miles south of Albuquerque, and 180 miles north of El Paso, has been having a series of trying but not dangerous earthquakes. Socorro has a population of about two thousand, and is located at an altitude of about 4500 feet. Dr. C. F. Blackington's handsome brick residence was considerably damaged.

Dr. James Willard Dudley, born in New York and aged 42, a graduate of the Harvard Medical School, '89, and an interne of the Boston City Hospital, '91, died at the Barlow Sanatorium from pulmonary and laryngeal tuberculosis on July 12th, 1906. An hour before his death he received a telegram from his class, which was holding its reunion at Cambridge.

Dr. Dudley contracted diphtheria during his last three months' service at the Boston City Hospital, while on service in the contagious wards, and never fully regained his strength, and in time fell a victim to the great white plague. He was a gentleman and a scholar, and had made a gallant fight against the world's great scourge.

Dr. Ernest W. Fleming, who spent some weeks recently in eastern medical centers, returned in time to take up his work as Professor of Otology, Laryngology and Rhinology, at the Los Angeles Post-Graduate School. Since his return he has again become an automobilist, although his former experience was anything but gratifying.

Dr. Frank P. Foster, in an able editorial in the *New York Medical Journal*, has come out very positively against the waiter using the same napkin to wipe the articles that he uses on the table, —such as knives, forks, spoons and plates—for the purpose also of wiping his hands and face and blowing his nose. We heartily endorse this heretofore overlooked reform.

Dr. Thomas B. Hart of Raton, New Mexico, was recently elected president of the New Mexico Medical Association. He has been in that city for twelve years, and is president of the Board of Pension Examiners, director of the New Mexico Insane Asylum, Health Officer for the city of Raton and Colfax county, county physician and medical superintendent of the Miners' Hospital. He is also chairman of the Republican Central

Committee, and a member of the Republican Territorial Executive Committee. He is also a member of the Nu Sigma Nu Fraternity.

Great Britain uses 50 tons of banana flour every year. This flour is made by drying the bananas and reducing them to a powder. The desiccation may be by sun heat, or with the aid of a drier or evaporator, while the reduction to powder can be done by means of a mortar and pestle or a grinding machine. The cost ranges from \$120.00 per ton to \$300.00 per ton. H. M. Stanley, the explorer, spoke in high terms of its efficacy in gastritis.

"Baron Larrey: A Sketch," by J. Chalmers Da Costa, M.D., is the leading article in the *Bulletin* of the Johns Hopkins Hospital for July. Baron Larrey was a military surgeon for over half a century. He participated in twenty-six campaigns, and "followed Napoleon with love that never failed, and with constancy that never faltered. Napoleon loved and trusted him; ennobled him; decorated him before the army; when at St. Helena referred to him in his will as 'the most virtuous man I have ever known,' and bequeathed to him 10,000 francs as a souvenir of enduring affection."

The Third Annual Convention of the California State Nurses' Association, convened in Los Angeles August 6th, 7th and 8th, at St. Paul's Parish House, Olive Street, opposite Sixth Street Park. The following program was carried out: Monday, 7 p.m.—Meeting of hospital superintendents; 7:30 p.m., meeting of State Councilors; 8:00 p.m., informal reception of visitors and delegates. Tuesday, a.m., p.m., and evening, business meetings, papers and discussions, as per official program. Wednesday, a.m., visiting hospitals; p.m., papers and discussions; 5:00 p.m., trip to Playa del Rey and supper.



The PRACTITIONER has received the following letter and enclosure from Dr. J. M. Burlew of Santa Ana:

DEAR DOCTOR: Enclosed please find a statement concerning the Santa Ana leper. I would be pleased to have it published in the SOUTHERN CALIFORNIA PRACTITIONER in justification of the procedure taken relative to the Santa Ana Chinaman.

Very truly,

J. M. BURLEW.

"THE SANTA ANA LEPER."

"The Santa Ana leper, a Chinaman resident of Santa Ana Chinatown, has passed away, and the excitement following the discovery of the case and the burning of Chinatown, has abated, and now it is but a memory, and an incident in the local history of the town.

"It was claimed by Los Angeles Chinamen, backed by their Los Angeles American medical advisers, that the

case was not one of leprosy, and that an injustice was being done the Chinks, through the ignorance of Santa Ana's physicians. The body of the Chinaman was therefore examined post-mortem. The immediate cause of death was pneumonia. The ulcers of the neck and various organs of the body have been examined by histological methods, and show all the characteristics of leprosy lesions. Sections from the ulcers of the neck were stained by Baumgarten's differential method (Pathological Technique, Mallory and Wright, page 389), through which hordes of acid-fast bacilli were demonstrated in the tissues, and thus differentiated from all other acid-fast bacilli, proving the presence of leprosy bacilli beyond all question of doubt. The various sections are preserved, and it will be a pleasure to demonstrate them."

## TWENTY-ONE YEARS AGO IN LOS ANGELES.

EXCERPTS FROM THE SOUTHERN CALIFORNIA PRACTITIONER, VOL. I. NUMBER 8, AUGUST, 1886.

"During the past ten years I have been frequently struck with the fact that a large percentage of the cases of consumption whose tenacity of life seemed well nigh marvelous, was due to a fibroid condition of the pulmonary tissue. My notebook contains so many cases put down to chronic pleuritis and interstitial pneumonia that I feel convinced that these fibroid deposits are not uncommon results in our consumptive cases, and offer us at least favorable prognostics. . . .

"In short, in a climate like ours, with favorable surroundings, I never despair of a case in which there is evidence of fibroid disease, be it ever so extensive. Prolongation of life at least may be prognosticated, and in most cases an almost entire relief from recurring pleurisies. We have, within a radius of from fifty

to one hundred miles, such a variety of climatic conditions that our patients may be sent to localities according to the individual necessities of each case, where a comfortable life, if not a positive cure, may be prognosticated. In these few observations no mention is made of treatment. A contribution will be made upon this question at some future time."

—*Excerpt from an original article on "Observations on Fibroid Phthisis," by Henry Worthington, M.D., Los Angeles, Cal.*

\* \* \*

"The SOUTHERN CALIFORNIA PRACTITIONER is the name of a new medical journal published at Los Angeles, California. It is bright, newsy and typographically neat. We notice the name of our old friend and school-fellow, Dr. Walter Lindley, appears as one of the

editors. Shake. Walter. *The Indiana Medical Journal* sends greeting and its best wishes for the success of the PRACTITIONER.—*Exchange Note from the Indiana Medical Journal.*

\* \* \*

"The old-fashioned house with its great rambling garret is a familiar recollection to those of us whose childhood dates back to the eastward slope of the continent. . . . There are other garrets besides those in old houses. Men's lives know of them. Every learned profession has them. . . . Theology has its garret, and it is a spacious one, and has for long ages occupied an important place in the religious history of the world. . . .

"Medicine is no exception to the rule. In fact, it not only has a garret, but its garret has to perform double duty. It is a common receptacle not only for old theories, but also for an antiquated materia medica. These theories, as, unlike the law or theology, they are not established by any legislative body or church council, generally fade away without much trouble; but the materia medica holds on to its rubbish with a more tenacious grasp. . . .

"Brethren of the medical profession, what shall we do with our garret? Can not some united effort be made to clear it out and take a new start? The science of medicine has plenty of drugs at its command of tried merit and virtue. Why encumber itself with all this accumulated rubbish?

"Brethren, let us have a house cleaning!—*Excerpt from an Editorial on "Garrets."*

\* \* \*

"Southern California has six great sanatoria of which Los Angeles is the center, viz; Santa Barbara, San Diego, Riverside, Pasadena, San Bernardino, and Los Angeles.

Santa Barbara is situated immediately on the coast, 125 miles north of Los Angeles. It is a beautiful little city of about 4000 inhabitants.

"Pasadena is a pretty, prosperous collection of beautiful homes, nestling close up to the Sierra Madre mountains, eight miles from Los Angeles, making it twenty-eight miles from the sea. This is where the Raymond, the grandest hotel in California, outside of San Francisco, is located. . . .

"The first point of interest was Long Beach, a beautiful, fashionable sea-side resort, twenty-five miles from Los Angeles, where a great Chautauqua circle, attended by thousands, was being held. . . .

"There are between thirty and forty regular practitioners in San Diego. Taken as a whole they are an elegant body of gentlemen—accomplished, thorough, enthusiastic physicians.

"We were surprised to learn that their was no organized medical society. With such material as there is in that city a first-class society could easily be maintained. It would be the means of acquainting one another with the many good qualities that each possesses, and thereby greatly increasing mutual respect and fellowship. Papers would be prepared setting forth actual facts in regard to San Diego climate, and much valuable information would be collected.

"THE SOUTHERN CALIFORNIA PRACTITIONER desires just such articles as the physicians of San Diego would prepare and read before their society. . . .

"We noticed several of the San Diego physicians had large iron safes in their offices, and we also learned that at least three of the leading practitioners each owned a large hotel, from which we would infer that from one point of view, at least, the visit of the invalid to the city on the bay has not been in vain. . . .

"Our visit to Riverside and San Bernardino we shall report in the next issue of the PRACTITIONER."—*Excerpt from an editorial on "An Editorial Trip in Southern California," by L.*

"The Philadelphia County Medical Society is prosecuting quacks. It is a pity the people cannot protect themselves from these advertising liars and out-laws."—*Editorial Note.*

\* \* \*

"Dr. J. H. Utley, Professor of Physiology in the Medical College of the University of Southern California, will return to Los Angeles in September. The Doctor has been doing special work in his branch in New York during the last few months."—*Editorial Note.*

\* \* \*

"Dr Joseph Kurtz and Dr. L. H. Nadeau have been appointed examining surgeons for Pensions in Los Angeles, by President Cleveland, vice Dr. J. P. Widney and Dr. Walter Lindley—offensive partisans. Dr. Kurtz will be particularly useful on the Board, as there are numerous cases to be examined, requiring an expert to diagnose the condition of the eye and ear."—*Editorial Note.*

\* \* \*

EDITOR OF THE PRACTITIONER:—"For some weeks almost all European and even a good many American papers have filled their columns with descriptions of the life and death of the unfortunate King of Bavaria. But of him—the noble physician—who lost his life in the attempt to save his royal patient from the waves of the deep court lake, of him whose life, in the eyes of a free American, has double the value of that of an eccentric king, we read scarcely anything.

"It seems as if the German press, which, as a rule, pays due respect to all the great scientists of the fatherland, has upon this occasion neglected its duty; and in offering tribute to a feeble-minded king, it forgets to pay homage to one of Germany's greatest physicians and scientists.

"Dr. von Gudden was an acknowledged authority in psychiatric medicine. A student of the great psychiatrist, Jacoby, of Sieburg, he had devoted his whole

life to this difficult specialty. He filled the chairs of psychiatric medicine at the Universities of Zurich and Munich, and until his sudden death was physician in chief of the Bavarian Insane Asylum. His success in all these positions is not only known in Germany, but all over the civilized world. The medical profession has lost, in this great scientist, a most valuable member.

"In dealing with the unfortunate insane patients, Dr. von Gudden employed all those modern means whereby our present age has distinguished itself. With true scientific knowledge he combined charity with great kindness. His habit of giving his recovering patients the utmost liberty has met with a great deal of opposition in professional circles.

"Upon due consideration the Bavarian government had decided to confine the insane King closely to his castle, but Dr. von Gudden guaranteed the safety of his royal patient, and the latter was left at liberty.

"Does it not almost seem as if this great goodness of heart of Dr. von Gudden has caused the loss of two valuable lives? No one knows. Yet, should even this assumption be true, it could not lessen our esteem for the great physician. He has lived the life of a noble man and died 'a true hero.'"

"SIEGMUND KNOFF,  
Medical Student."

"Los Angeles, Sept. 15, 1886."

—*Letter in the correspondence column of the PRACTITIONER of October, 1886.*

LOSS OF BLOOD IN CONFINEMENT.—The average loss of blood in the ordinary confinement is less than one pint. The loss of thirty-two ounces (two pints) is not alarming in a vigorous, healthy woman, but would be in a weakling. The danger line is manifested by pallor, cold extremities, cold sweat, rapid, small pulse, yawning, thirst, gasping for breath (air hunger), dizziness, faintness and anxiety of countenance.



## MISCELLANEOUS.

## RABELAIS AS A PHYSICIAN.

It is a matter of common knowledge that the creator of *Gargantua* began life as a monk, and after passing from one order to another, gathering vast erudition on the way, threw off the cowl and replaced it with the doctor's cap. He was about 40 when he entered the University of Montpellier as a student of medicine. His progress was amazingly rapid, for having matriculated on September 17, 1530, he became a bachelor of medicine on December 1st following. He forthwith began to lecture on the Aphorisms of Hippocrates and the *Ars Parva* of Galen. Towards the close of 1531 he was appointed physician to the Hotel-Dieu at Lyons, and though he was only a bachelor, assumed the title of doctor—an early instance of a practice which has since become common enough. The irregularity of his attendance got him into trouble with the hospital authorities, and in 1535 his services were dispensed with. Returning to Montpellier, he studied for some time, and in April, 1537, passed his examination for the degree of licentiate. Promotion to that of doctor followed in due course. Rabelais, notwithstanding the somewhat erratic character of his studies, gives in his famous work innumerable proofs of his thorough knowledge of the medical science of his day. He is fond of anatomical details, which are generally remarkably accurate; he is known to have practiced dissection at Montpellier, and a claim has seriously been put forward on his behalf that he was a pioneer of scientific anatomy before Vesalius. He modified an apparatus for the treatment of fractured leg described by Galen and gave it the imposing name of "glossocomion." Although the drawing of his apparatus gives one the impression of an antique engine of war, it seems to have been regarded as a distinct im-

provement in surgical practice; and so great a man as Ambroise Pare did Rabelais the honor of appropriating the invention without thinking it necessary to mention from whom he had got the idea. Rabelais also devised a syringotome or probe-pointed garded bistoury, which was used to divide the peritoneum in penetrating wounds of the abdomen. Of Rabelais's medical practice, whether at Lyons or elsewhere, little is known. He was titular physician to princes of the Church, such as Cardinal du Bellay and Cardinal de Langey, but it may be conjectured that this position was for his own protection rather than theirs. There is, indeed, evidence that in 1540 he was consulted by the Bishop of Narbonne on a matter as to which he may have been supposed to possess special enlightenment. The case propounded to him was as follows: Philippus Saccus, President of Milan, had taken counsel of the doctors of Bologna and Venice on the question whether a daughter who had just been born unto him could be regarded as got 'twixt the lawful sheets. It was on October 26, 1539, at the fourth hour of the night before the new moon that the president first had carnal knowledge of his wife; and long before the nine months required by nature were fulfilled a fine girl, having all the appearance of being a full term child, had made her entry on the stage of the world. Unfortunately there is no record of Rabelais's solution of the problem. In a thesis presented not long ago to the medical faculty of the University of Paris for the degree of doctor of medicine, M. Maurice Mollet deals with Rabelais as a clinician. A fairly complete notion of the therapeutics of the sixteenth century may be obtained from his writings. He not only mentions the remedies, but indicates their uses, and by the extravagant

praise bestowed upon some of them evidently intends to ridicule the folly or superstition of those who believed in their virtues. He invented a condiment made of salted fish, "garus," anchovy, or sardine, seasoned with various spices, which he called, *garum*, and recommended to his friend, Etienne Dolet, as the best thing for a man who passed his life bent over books, to restore appetite, purge the humors, and move the bowels. This green sauce, whose virtues were celebrated by Dolet in Latin, and by Clément Marot in French verses, had a great vogue for some time, and is still used in a much modified form in some villages of the South of France.—*New York Medical Journal*.

#### ASEPTIC OPERATING.

H. T. Byford, Chicago, (*Journal A. M. A.*, March 11), objects to rubber gloves and impervious covering of the hands on the ground that they produce sweating, and that a scratch or puncture would liberate the accumulation of germ laden perspiration. He advises soaking the hands thoroughly to soften the cuticle and to loosen the dirt between the epithelial scales, and for this purpose he prefers water drawn in a basin and frequently changed to running water. After soaking the hands and scrubbing them with green soap he advises a scrubbing with diluted acetic, citric or oxalic acid. This in turn is followed by soaking in 90 per cent. alcohol and then in a 1-1000 solution of bichloride of mercury. In protracted operations, he advises dipping the hands in the mercuric solution every 10 or 15 minutes to insure asepsis. He does not believe in mixing the solutions of alcohol, green soap, etc., but prefers to keep them separate, and he objects also to sterilized sleeves. Of equal importance is the sterilization of the field of operation. It is easy to sterilize the abdomen, but it is more difficult in case of the

groin or genitalia. The shaving should be carefully done to avoid abrasions and the parts scrubbed, not only with soap, but with alcohol and mercuric chlorid, and minor operations should receive the same attention as the major. The best after-dressing is sterilized gauze shreds over the sutures and a thick layer of sterilized gauze over these. Inguinal wounds should be washed off after six days and then covered with dry sterile gauze, to be removed daily or otherwise as occasion requires. Dry dressings over peritoneal sutures should be changed every four hours or oftener if they become saturated.

#### VACCINATION VS SMALLPOX.

Dr. J. F. Schamburg, lecturing in Philadelphia the other evening, stated that of more than three thousand smallpox patients treated at the Philadelphia Municipal Hospital during the last three years not one had been recently successfully vaccinated. None of the medical attendants were attacked. Of one hundred women workmen employed near the patients four refused to be vaccinated. These were stricken with smallpox, while those who submitted to the operation were unscathed. Of seven hundred medical students who have worked in smallpox wards only one caught the infection, and he had never been successfully vaccinated. If any evidence is good for anything, this is proof that failure to be vaccinated is an opportunity for smallpox. No such combination of circumstances as are here recorded could be without a reason, and the reason is clear enough. If a person persists in not being vaccinated, he multiplies his chances of having smallpox.—*The Medical Examiner*.

#### THE EDIBILITY OF ANIMAL SPLEENS.

E. T. Williams (*American Medicine*, Feb. 10), in the course of investigations on animal spleens found them good to eat. He cooked them in various ways

and tested them on his friends. They contain  $\frac{3}{4}$  gr. iron and  $1\frac{1}{2}$  gr. phosphorus per ounce. When raw they have a pulpy consistency which renders them unfit to eat. Heat coagulates their free albumen, and gives them a consistency to be cut and chewed. They must be eaten quite fresh. They decompose rapidly and cannot be kept over night, even on ice. To be safely eaten they must, of course, be healthy. All infectious diseases are liable to affect the spleen. All diseased spleens should be rigidly excluded. Dr. Williams concludes with general remarks on the dietetic value of spleens as a blood-making food.

The number of spleens available for food purposes is almost without limit. A rough estimate based on the United States Census Report reveals the fact that there are upward of 50,000,000 pounds of edible spleens thrown away yearly in the United States. This includes the spleens of cattle, hogs and sheep. An ox spleen weighs upward of 2 lbs., a hog's spleen about 1 lb., a sheep's spleen 4 oz., on the average. It is easy to see what an enormous amount of good food is thus wasted every year. The commercial value of these spleens reckoned at ten cents per pound would be about \$5,000,000 per annum.

#### THE DIAMETERS OF THE NORMAL AND THE PHTHISICAL CHEST.

From a study of the chest measurements of 502 normal individuals and in 54 tuberculous cases, using bony landmarks for locating the length and diameters of the chest, W. A. Bessesen, Chicago (*Journal A. M. A.*, December 30), deduces in substance the following conclusions: 1. The use of bony landmarks for locating chest diameters is accurate and easily applied. 2. The use of median values for evaluating anthropometric data saves time and the results are more accurate than the arithmetical average. 3. Important

points in the shape of the chest, as well as the movements and capacity, may be appreciated by observation of its principal diameters. 4. The development of the human chest passes through various stages from the deep or dorsoventral to the broad or transverse type. 5. In the fetus and young babe, the lower plane gives a greater depth and breadth than the mid-plane. 6. The fetus under 30 centimeters in length presents a dorsoventral type of chest—it is deep chested. 7. The new-born child represents the transitional type of chest—it is round chested. 8. During the first five years of life the most notable change is the rapid widening of the chest in its transverse diameter—it becomes broad chested. 9. At puberty the chest takes on an increase in length over the diameters—the adolescent becomes long chested. 10. From the eighteenth to the twenty-fifth year the development of the chest is fairly uniform in all its dimensions and represents the highest development—the broad long chest. 11. The dorsoventral diameter increases at an even rate from birth to maturity. 12. The phthisical chest of adult years, in general, shows an arrest in development of the transverse diameter following puberty. 13. The phthisical chest is a narrow one, tending to the rounded form, with a relative elongation. A number of tables are given with the text.

CAMPHOR IN MORPHINISM.—Erlenmeyer, in *La Tribune Medicale*, states that when morphine is withdrawn from an *habitué*, camphor is an excellent remedy to support the heart, acting both as a vasoconstrictor and very energetic cardiac tonic.

LIME WATER AND SWEET OIL, mixed in equal parts is a splendid application for burns.



## BOOK REVIEWS.

**THE PRACTICAL MEDICAL SERIES.** Comprising ten volumes on the year's progress in medicine and surgery. Under the general editorial charge of Gustavus P. Head, M.D.: Professor of Laryngology and Rhinology, Chicago Post-Graduate Medical School. Vol. 8, The Eye, Ear, Nose and Throat, edited by Casey A. Wood, C.N., M.D., D.C., L.; Albert H. Andrews, M.D.; Gustavus P. Head, M.D. Series 1906, Chicago. "The Year Book Publishers." 49 Dearborn St. Single vols., \$1.50; the series of ten volumes, \$19.00.

This volume is one of a series of ten, issued at intervals of about a month, which cover the entire field of medicine and surgery. Each volume is complete for the year prior to its publication on the subject or subjects of which it treats.

In this volume the reviewer finds much that escapes his notice in the general literature during the year. The condensing and quoting has been skillfully done; the paragraphs are terse, but clear; and the authority and source are so placed that one desiring to read the whole article knows where to find it at once.

The revised second edition of "Diseases of Children," by Drs. Taylor and Wells, published by P. Blakiston's Son & Co., of Philadelphia, has been translated into Italian by Dr. Mario Flamini of the Pediatric Clinic of Rome. This translation is having a great sale.

**A COMPEND OF OPERATIVE GYNECOLOGY.** Based on Lectures in the Course of Operative Gynecology on the Cadaver at the New York Post-Graduate Medical School and Hospital. Delivered by William Seaman Bainbridge, M.D., Adjunct Professor of Operative Gynecology on the Cadaver, New York Post-Graduate Medical School and Hospital; Consulting Gynecologist, St. Mary's Hospital, Jamaica, L. I.; Consulting Gynecologist to St. Andrew's Convalescent Hospital, New York, etc. Compiled, with additional Notes in Collaboration with Harold D. Mosker, M.D., Instructor in Operative Gynecology on the Cadaver, New York Post-Graduate Medical School and Hospital; Assistant, Department of Gynecology, Vanderbilt Clinic, College of Physicians and Surgeons, New York. 12 mo., cloth, 76 pages. Price \$1.00 net. The Grifton Press Publishers, New York City.

**SURGICAL SUGGESTIONS.** Practical Brevities in Surgical Diagnosis and Treatment. By Walter M. Brickner, M.D., Chief of Surgical Department, Mount Sinai Hospital Dispensary, New York; Editor *American Journal of Surgery*, and EH Moschowitz, M.D., Assistant Physician, Mount Sinai Hospital Dispensary, New York. Editorial Associate, *American Journal of Surgery*. Duodecimo, 66 pages. New York: Surgery Publishing Co., 1906. Cloth, 30 cents.

**A TEXT-BOOK OF MATERIA MEDICA, THERAPEUTICS AND PHARMACOLOGY.** By George F. Butler, Ph.G., M.D., Associate Professor of Therapeutics in the College of Physicians and Surgeons, Chicago; Professor of Medicine and Therapeutics, Dearborn Medical College, Chicago. Fifth edition, thoroughly revised and rewritten, and adapted to the Eighth Revision (1905) of the U. S. Pharmacopoeia, by Smith Ely Jelliffe, M.D., Ph.D., Professor of Pharmacognosy and Instructor in Materia Medica and Therapeutics in Columbia University (College of Physicians and Surgeons), New York. Philadelphia and London, W. B. Saunders Company, 1906. 624 pages, \$4.00 net.

This well-known text-book presents a comprehensive consideration of the Pharmacopoeia of the United States, brought down to the Eighth Decennial Revision. The general arrangement of the subject-matter embodies a synthetic classification of drugs based upon therapeutic affinities. In discussing the action of drugs, the "untoward action," i. e., the effects of medicinal doses in developing certain symptoms dependent more or less upon individual susceptibility, and not necessarily assuming the exaggerated form incident to toxic doses, are considered separate and distinct from "poisoning."

All the drugs, the predominant actions of which are on one system of organs of the body, are grouped together, thus suggesting their therapeutic as well as their pharmacological alliances. In addition to the general index, there is also a clinical index.

This text-book of materia medica, therapeutics and pharmacology should be of value not only to students, but to practitioners as well.

## THERAPEUTICAL HINTS.

## X-RAY BURNS.

At the 337th regular meeting of the New York Dermatological Society, held November 28th, 1905, the subject of X-ray burns was taken up, and Dr. Henry G. Piffard, Emeritus Professor of Dermatology in New York University said, according to the *Journal of Cutaneous Diseases*, "that he had obtained the most benefit in treating these conditions from Antiphlogistine, chloride of zinc, high frequency current and ultra violet rays."

To young girls arriving at womanhood, many times laboring under abnormal mental strain from over-study and from the additional nervous tension due to the first menstruation, Hayden's Viburnum Compound is particularly serviceable. It is a uterine sedative and calmative and assists in the normalization of the pelvic circulation. Hayden's Viburnum Compound has stood the test of time, and for twenty-five years has been accepted and recognized as the remedy in the treatment of Dysmenorrhea, Amenorrhea, Menorrhagia and other diseases of the uterus and its appendages. To secure results the genuine H. V. C. only should be administered. Literature on request and sample if express charges are paid. New York Pharmaceutical Co., Bedford Springs, Mass.

Abbott's Alkaloidal Digest, by W. C. Abbott, M. D., editor of the *American Journal of Clinical Medicine*, and published by the Clinic Publishing Co., Chicago, is a neat little book that is devoted particularly to exploiting the virtues of Alkaloidal Granules and Tablets. It will be sent free to any physician on application.

Tyree's Antiseptic Powder is pre-eminently satisfactory in cases of

prickly heat. It does not clog the pores of the skin, but acts as a deodorizing, stimulating agent. Sample and particulars on application to J. S. Tyree, Chemist, Washington, D. C.

Beef was used for food several thousand years before Christ, and cattle are mentioned in the Bible 150 times. Armour & Co. have been manufacturing a soluble beef for about seven years, and this excellent product has met with a hearty reception at the hands of the profession and the public at large. Physicians who have not yet been convinced of the value of soluble beef should write Armour & Co., Chicago, for samples.

Dr. Crile of Cleveland, Ohio, advocates the sustained administration of a weak solution of Adrenalin-chloride in preference to the occasional application of a strong solution. In the treatment of hay fever the weak solutions of Adrenalin-chloride frequently applied are apt to yield the best results.

Glyco-Thymoline is valuable in the treatment of diseases of the nose and throat, but it also has particular virtue as a prophylactic. The use of Glyco-Thymoline as a gargle and nasal spray twice a day will almost absolutely prevent tonsillitis and other infectious diseases of the air passages.

"George Washington's Physician, Their Friendship and His Treatment During the President's Last Illness," is the title of a most interesting little booklet published by J. S. Tyree, the chemist, of Washington, D. C. It is of much interest to physicians, as it contains much unpublished history relating to this noble old physician and his devotion to President Washington. The engravings of the doctor and Mount Vernon are both excel-

lent. Every member of the medical, dental and pharmaceutical professions should possess a copy of this little booklet, which we understand Dr. Tyree is mailing free of cost, for a limited time, with the assurance that no requests for copies will be made public.

IT HAS BEEN SUGGESTED THAT irritation of the bladder during pregnancy is caused by the uterus pressing against it, and is most likely to occur as the uterus grows out of the pelvis, about the third month of pregnancy, and at the end of pregnancy or the beginning of labor, when the child's head is entering the pelvis. As a result of this pressure, the patient has a desire to pass urine every few minutes. In the first case this may be overcome by having the patient take a knee-chest posture or by having her lie on her stomach a few minutes night and morning.

IT IS SAID that the administration of large doses of sodium salicylate,

given by rectum to avoid gastric disturbances, forms the most satisfactory plan of treatment for cerebrospinal meningitis; that an effective remedy for cerebrospinal meningitis must travel the same road which the infectious germ has taken through the blood current. Salicylates have been used before in this condition, but in doses that are entirely too small. According to the age of the patients, sodium salicylate is given by rectum in fifteen-grain doses dissolved in a tablespoonful of water, at intervals of from one to eight hours, the salicylization being gradually reduced as improvement follows.

THE DIFFICULTY THAT MOST PERSONS EXPERIENCE in lying on the left side is attributed to the lack of support of the heart by the other organs in this position. Hence the heart becomes more flaccid and requires greater effort to empty itself, the respirations being correspondingly increased.



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# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTINGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## THE PHYSICIAN'S DUTY TO HIS FELLOW PRACTITIONER.\*

BY WALTER LINDLEY, M.D., LL.D., LOS ANGELES, DEAN OF THE COLLEGE OF MEDICINE OF  
THE UNIVERSITY OF SOUTHERN CALIFORNIA.

The physician's duty to his fellow-practitioner and to himself makes the complex subject of my talk today.

The physician should be an educated gentleman. It is too late to talk to you of the Senior Class in regard to your own preliminary education. The die is cast as far as that is concerned, yet you will have your influence on many young men who are to follow in your footsteps. Urge all to secure a well-founded general education before beginning their professional course. The medical student who has the education that is represented by the degree of A.B. or B.S. is to be congratulated. The time will soon come when at least an experience of two years in a college of liberal arts will be required to gain matriculation in any reputable medical college. Speed the day.

Mathematics, English, Latin, Greek and Chemistry are the foundation branches. Botany and Zoology are both important. If any of you are unfortunate enough not to have had a well-rounded preliminary education, then you should take up at least two of these

studies with a tutor or a correspondence school and keep on until you have secured that education that is expected from a gentleman in one of the learned professions.

Become thorough in the metric system of weights and measures. Learn to write your prescriptions in that system. This is very difficult for the elderly physician who was not taught this system, but you young men must learn it. Try to get to thinking in the metric system. The metric system has come into my life so recently that I have to translate kilogram into pounds and ounces and meter into inches before I have a real conception of how much they mean.

The metric system originated in France in 1790, and has been adopted by forty-two other countries, *i. e.*, by all civilized and semi-civilized countries, excepting Great Britain, the United States and Russia. It was adopted by the United States Pharmacopeia of 1890, and is largely used in many sections of the United States. It is generally conceded that the system, while simple and uni-

\* Delivered before the Senior Class of the College of Medicine of the University of Southern California, May, 1906.

form, affords a facility of computation which renders it superior to all other systems of weights and measures.

1. It is orderly, clear and logical.
2. There are no specific trade tables, such as *avoirdupois*, wine measure, grain measure, etc.
3. The single ratio of ten is involved, thus making calculations extremely simple.

In order to minimize difficulties in writing prescriptions, as far as possible, it has become the custom in things medical to use only two metrical terms, the gram (gm.) and the cubic centimeter (cc.).

Every first-class pharmacist thoroughly understands the metric system. It would pay you well to practice writing prescriptions in the metric system ten or fifteen minutes every evening. You do not need a teacher for this; you can teach yourselves.

Take advantage of every opportunity to learn the Spanish language. Mexico invites us. Panama will be the great avenue that we will travel. The South American republics will be brought nearer and nearer to us. The Philippine Islands and Porto Rico are part of the United States, while our relations with Cuba are bound to always be intimate. It is a beautiful, musical language. Learn it and there will be opened to you many doors to success that would otherwise be sealed.

If you have limited means, begin now and select book by book a general library. Spend an hour now and then in a second-hand book store, and get your Hugo and Goldsmith, your Eliot and Johnson, your Macaulay and Tennyson, your Dickens and Tolstoi, your Poe and Swinburne, and your books of reference. Buying your library this way, you will love each book as it comes to your grand salon where the old masters are your guests.

In regard to your medical library:

Do not spend much money on it. Do not buy any systems of medicine to be paid for on the installment plan. Those installments will be sure to come due just when you are in the greatest financial stress. Systems of medicine are generally a delusion and a snare. Buy one good book now and then—not too often. Study what you do buy. Take at least two medical journals, one weekly and one monthly. Then, if you can afford it, take one special journal on surgery, obstetrics, nervous diseases, or whatever line you are most interested in. Keep ample note of all your cases. These notes will make your most valuable library.

Whenever you have an interesting case, write it up for your medical society. Read and speak before your society whenever you can. Take occasion to speak briefly and concisely in public as often as possible. Practice public speaking on every possible audience. Naturally you may be ever so diffident, but you can soon educate yourself to think on your feet and to express yourself in a clear and interesting style. To speak slowly, enunciate distinctly, and pitch your voice according to the hall in which you may be speaking, are the three cardinal points in delivery.

Financially, you must save a little money—not too much—and then invest your savings judiciously. Do not be miserly, but live according to your station in life, even though it may be some time before you can save anything. Never keep over \$100 in a savings bank. Savings banks are good for old women and children. Never invest your money in outside enterprises like mercantile or manufacturing companies. Do not buy a farm. Do not invest in mining stock, oil stock, rubber plantations or any of these big enterprises, the end of which no person can foresee. The best investments are town or city real estate, bank stock, township, city, state or national bonds. Go in debt for a lot. Study the

location of the lot and be sure that you invest in the line of growth.

Very few men make money without going in debt. Do not go in debt for more than you know you can pay, and, when you do go in debt, pay, if it takes you years. Never speculate. Never invest in anything that is going to pay "big." Such propositions are invariably a gamble. Never go security for any man.

Do not be in a hurry to marry. The medical student, the interne, the young practitioner is very likely to be, to use the language of Balzac, "Like all unprotected boys, he loves the first woman who throws him a kind look." Wait until you have settled into a substantial practice, until your judgment is mature, until your tastes have become discriminating. Let me urge you to summon all of your will power to resist that youthful tide of passion that sweeps so many young men off their feet and results so frequently in an unfortunate *mesalliance*. The professional man has no time for marriage before he is thirty. If he graduates young, there is all the more reason that he should devote himself to post-graduate study instead of occupying his time with the anxieties, cares and affections of his wife and his offspring. It is due those who employ you in your sacred calling that you give these early years to professional preparation and that you, for the time being, sacrifice your personal desires for the felicities of domestic life. Marry, by all means; marry some good, pure woman, loyal and true, but do not marry until your education is somewhat rounded in practical experience, and you are thoroughly established professionally.

Attend to your patients carefully, thoroughly, conscientiously; charge reasonably; save and invest conservatively. By so doing, if you have health, you will accumulate a competence and

may eventually become financially independent.

Your duty to your fellow-practitioner? Act as one gentleman naturally would to another. Rules and codes of ethics are only necessary for those who have not the instincts of gentlemen. Never envy another physician. There is just one way that you are justified in taking patients from another doctor, and that is by being better qualified than he. Yes, there is an additional thing you may do, and that is to be faithful in your office hours.

You should get the good will of the community in which you live. Become a part of that community. Attend the club, the church, the lodge. In other words do your part in carrying the burdens of your community. Take some part in the political party whose tenets come the nearest meeting your approval. All of these things you should do through patriotism and not through policy.

Take an active part in the medical societies. If you will attend regularly, read a paper whenever called upon, report cases, take part in discussion whenever opportunity offers, you will find that your society is really a post-graduate school.

Help make your medical society; help build it up.

In your society, in your town and in your state be history makers. The intelligent physician is always expected to be a leader. Let your leadership be for the best interest of your profession and for the best interest of the community in which you live.

Do not be narrow and hide-bound in regard to the medicines you prescribe or the men with whom you consult. Take the homeopathist, eclectic, or masseur on his merit. Some of the best ideas a young practitioner will get come from some good old lady who has raised a family of children. Do not despise the fruits of experience. Sometimes these old ladies may puzzle you with questions.



Just be deliberate about answering and they will answer their own questions. This method never fails.

There is a great deal being said now about not prescribing so-called proprietary medicines. You simply prescribe what is best for your patient, regardless of the preaching of the zealot who proposes that every person else must follow in his own narrow, contracted path.

In entering a new town you had better call on all of the physicians, if it is a small town, but if it is a city, call on the officers of the medical society and a few of the leading men.

Be ready to call in a consultant in every serious case, and in all cases where the patient or his friends show the least desire for additional advice. It is dangerous to tell a patient that you are willing to call in any person he wants. Tactfully endeavor to have some person called who is able and honorable. Do not start into a consultation determined that it shall be a mere form and with your mind irrevocably made up. Put yourself in a receptive state. Try to avoid discussing the case before the patient. After your consultant has examined your patient, you should both retire and privately decide the course of treatment to be pursued. In regard to the fee. It is very nice for the attending physician to collect the consultant's fee.

Do not be jealous and suspicious of older practitioners. Maeterlinck says: "A man who is good attracts with irresistible force events as good as he." If you are suspicious and envious of your fellow-practitioners, your own course will make them suspicious of you, and soon you will be working at cross purposes, and men who should be your friends will become your enemies.

In a recent address on "The Ideal Doctor," Dr. David W. Cheever, the Boston surgeon, who is really himself America's ideal doctor, said: "Altruism

is sacrificing self to others, and egoism is sacrificing others to self. The relations between doctor and patient are so peculiar as to require a blending of altruism and egoism, of self-denial and self-assertion. . . . The ideal doctor looks after the interests of his brother physicians; he says no evil. . . . He who has a healthy body, he whose mouth is shut, whose heart is kind, whose intentions are sincere, who does his best, who treats his patient as himself, who looks after justice as well as mercy in his dealings, is altruistic and egoistic both, is the ideal doctor." "Whose mouth is shut,"—do not ever permit yourself to be drawn into making an adverse criticism of a fellow-practitioner. It lowers you in the eyes of all who hear you. Although you might be honest in your criticism, yet there is a possibility that you may be unjust, because you cannot place full credence in what the laity tells you a certain doctor may say or do. If you are told that a brother physician has done you a serious injustice, do not believe the story, but go and see him and tell him the report.

The young physician without a *chênle* is likely to be hypersensitive and shut himself up in his shell whenever the older, prosperous practitioner approaches. Many times this extreme independence or false pride prevents the successful older man from extending a helping hand. Almost every busy practitioner wants several understudies. "I do not want to be satellite to Dr. Jones," the stiff-necked young fellow may say. That is a bad spirit. While you are a "satellite," you will have an opportunity to gain knowledge, to gain experience, and to gain an acquaintance that will give you Dr. Jones's overflow, and thus will lay the foundation for a practice of your own. This may come slowly, but it will come.

To lay down rules for the conduct of gentlemen in their relations with each other is puerile. It is sometimes neces-

sary to tell boors how to imitate gentlemen. The effort at imitation is laudable, but always transparent. The foundation of all ethics is the golden rule. When you enter the active practice of your profession, do so with the determination that you will deal mercifully, fairly and honorably with all people, and you will never need to study

any code of ethics. For the sake of yourselves and your happiness in life, carry yourselves so that you will each day do the work that comes to your hand in the most thorough, unostentatious and beneficent manner possible, and you will thus leave to your children a noble heritage and add to the prestige and renown of this, your alma mater.

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## EUROPEAN SURGERY.

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A LETTER TO THE EDITOR FROM DR. ANDREW STEWART LOBINGIER, LOS ANGELES.

BERLIN, Aug. 2, 1906.

*To the Editor:*

In keeping my promise to write a letter for the *PRACTITIONER* while abroad I am conscious that some of the ground I am going over is familiar to a number of your readers. Men and methods, however, are constantly undergoing change and I can see many evidences of this change from conditions prevailing four years ago.

Most of the men visited are masters in their special fields. They were personally known to me and I saw them in their private work, where a more intimate observation is to be obtained. It affords an opportunity to discuss the diagnosis and operative procedure not permitted in an open clinic.

Directly on landing at Liverpool, I went to Leeds to be with Mr. Moynihan, with whom an appointment had been previously made.

He is assistant surgeon at the Leeds Infirmary, and lectures on surgery in the university. Mr. Moynihan is well-known to Americans now through his writings and his visit there. I wrote you of this brilliant young surgeon when I visited him in 1902 and then predicted the eminence and fame to which he has risen. His former chief and teacher Mr. Mayo Robson, retired from the senior service at Leeds three years ago and since then has been in London.

Moynihan has still four years to serve before he will attain the senior position. He is just forty, and as the senior service at Leeds is twenty years, he will be sixty-four when it is terminated. When asked if London would not claim him long before, he answered in his prompt, incisive way, that he preferred Leeds to London as his field of work. His wife is the beautiful daughter of Mr. Jessop. Mr. Jessop's name with the Heys', has long lent lustre to the surgery of Leeds. My visit of a week with Mr. Moynihan has confirmed my first impressions of him and brought me to love him for his kindly courtesies as well as to admire him for the brilliance of his mind and his masterly operative skill.

He is a warm admirer of the rigid technic in asepsis seen in the best operating rooms in America and of the American surgeons who enforce it. He frankly said he had adopted these aseptic ideas, and it was quite apparent both in the Infirmary and in the Nurses' Home where his private work is done.

I had the pleasure of seeing him do a number of interesting stomach and gall bladder operations. From one morning I recall four gastro-enterostomies, three of which were in patients suffering from duodenal ulcer. Mr. Moynihan does a most graceful and artistic gastroenterostomy; I have never seen it surpassed, and he has perfected

his technic until it would seem well nigh faultless. Of the last series of something over 140 gastroenterostomies he has not had a death. There were many new ideas learned here in diagnosis and improved technic.

I left Moynihan with great reluctance. He is a rare spirit and doing a magnificent work, with one of the largest and most lucrative practices in the British Kingdom. He is a tireless worker, high-minded and full of the spirit which marks the genius and the scholar.

During the intervals between operative work, the time was spent seeing again the beauties of Yorkshire—Studley Park, Fountain's Abbey, Scarborough, York and Bolton's Abbey. Eight days after my arrival I left Leeds for London. On the way I stopped at Leamington, visiting Stratford-on-Avon and Warwick and later seeing the Warwick Pageant on the castle grounds. Over two thousand took part in this remarkable outdoor, historic play. It covered five hundred years of the interesting history of Warwickshire. Oxford University was next visited and from there I went down the Thames to the Henley regatta. It was the day of the "finals" and a day England will long remember as the first in her fine history of rowing, to lose to another country the grand challenge cup. Belgium took it with a splendid eight.

On reaching London my time was spent chiefly with Sir Victor Horsley and Mr. A. W. Mayo Robson, as had been arranged before leaving Los Angeles.

When Mr. Robson came to London he already had a fine clientele in this capital. Most of his former following remained loyal and to them he has added many of the most prominent people of England. "Nurses' Homes" were founded for him by nurses who had cared for his patients at Leeds and had followed him to London to establish hospitals for the care of his private patients there. He keeps three such es-

tablishments filled with surgical patients, but has no pecuniary interest in any of them. The remarkable energy and method with which he works enable him to accomplish an unusual amount of work in a day. A portion of the afternoon he spends in his office in his elegant residence in Park Crescent. It is just a few doors from Lord Lister's home. The custom of having the office in the residence prevails in London as in Eastern America.

It seems that London has already benefited by Mr. Robson's work and example. If one were to consider but a single field of the many in surgery in which Mr. Robson's talent has developed unusual investigative qualities, as that of the gall bladder and ducts, the pancreas, duodenum and pylorus, it may be truthfully said that what we know of the surgical pathology of this region today we owe very largely to him. To my mind his judgment and operative genius in the right hypochondrium are remarkable. He certainly is to be regarded as one of the most judicious, skilful and versatile surgeons living and one of the first and greatest of teachers on the gall bladder and pancreas. Prof. Keen has asked him to write the chapters on these subjects for his new work, and Mr. Moynihan is to contribute a chapter also. In the spring Saunders will publish an extensive work on the Pancreas and Pancreatic Surgery by Mr. Robson. Mr. Carmidge, his laboratory assistant, will aid in the preparation of the work. I had the privilege, with Mr. Robson, of observing a large number of cases of chronic pancreatitis, as well as the many cases of stomach and gall bladder disease, which might be expected to be seen under his care. Many of these were of great pathologic interest and were operated in his usual masterly way. His courtesy and kindness were unfailing and I was the recipient of social favors from him, which added greatly to the pleasures of my stay in London. From lack of time I was compelled to decline



a most enticing invitation to spend a week with him stag shooting in Scotland, in September. He has a forest of thirty thousand acres richly stocked with deer and other game, where he goes every autumn for his holiday. It was with especial delight that I met Sir Victor and Lady Horsley again. I had been their guest at Littledale Hall in 1902, during a portion of the grouse season. I am to join them again on their return from Toronto, at Westwick, Norfolk, where they have had a large preserve for the past three years. Sir Victor has but recently recovered from a severe illness. He had just concluded his University Hospital service, but I was with him in some very interesting private work. A case of Jacksonian epilepsy was of unusual interest. Horsley is the most dextrous operator I have ever seen work on the brain. When I visited him before I was struck with his remarkable intellect and a versatility which made him at home in any field of scientific discussion.

I had known of his work for twenty years and was prepared to find a much older man. He was then 43; last April he celebrated his 47th birthday. For twenty-five years he has been known to the surgical world as the principal authority in the surgery of the brain and spinal cord. That would make him a leading authority on this subject at 23. It seems incredible, but when one comes to know him intimately and observe the keen, exact quality of his mind, one can understand how he became eminent so young.

Apart from his abilities as a great investigator and laboratory worker, he is a remarkable operator. An intimate knowledge of the minute anatomy and pathology of the brain and a smooth, facile dexterity in the use of instruments, are the most striking features a casual observer would note. But beneath this is a vast learning gathered from every source of collateral science and a quarter of a century of exact experimental

and clinical study in one special and difficult field.

The accumulations of clinical and experimental evidence from these years of accurate work would form remarkable volumes.

The increasing duties of his enormous practice have prevented his writing out and publishing these valuable observations. When I asked him why he had contributed so little to surgical literature during the last decade he answered that he simply could not take the time to write and could find no assistant who would satisfactorily collaborate the data and material he possessed. It is a great pity and one can only hope he will yet be able to put in permanent and tangible form this invaluable material gathered from a field where he has so long been leader and master. When I left London he was preparing to visit Toronto, where he delivers the address on surgery before the British Medical Association. He returns immediately thereafter to England to spend his holiday in partridge shooting on the "Broadlands of Norfolk." He is the prince in hospitality and sport as he is in science, and he that is fortunate enough to be his guest can never forget it.

Among other surgeons of note in London whom I visited and saw work were Mr. Bland Sutton, Mr. Charles Ballance, Mr. Donald Armour and Mr. Sargent. The first two very able surgeons and authors are well known to Americans. The other two are younger men who are doing excellent work.

After leaving London my experiences were of no professional interest, passing through Belgium and Holland and up Rhine until I reached Heidelberg. When I called on Prof. Czerny I learned with much sorrow that Prof. Petersen was very ill and had been compelled to give up his work in surgery. He had recently been called to direct a large surgical hospital in Leipsic, but was unable to continue with it. With Mikulicz and Petersen gone, Germany has lost two of

her brightest young minds in surgery. Czerny seemed greatly affected and said the university felt deeply Petersen's loss and that personally he could scarcely be reconciled to it. All who have followed Petersen's brilliant work will agree, I think, that his early recognition of the direct axis in gastroenterostomy and the elimination of the loop and with it the "vicious circle," has been one of the most valuable contributions to modern surgery. And that is but one of the many good things in technic he has contributed. It was a pleasure to hear Mr. Moynihan bear testimony to Petersen's genius, although he had never met him. I had gone almost directly in 1902 from the Leeds clinic to be with Petersen, and the work he was doing then and his results had impressed me deeply. I saw for the first time then the snug no-loop anastomosis. The admirable results which followed this technic were sufficient to convince one of its merit.

Prof. Czerny was most kind. I have nowhere had more courteous treatment than during the ten days spent in Heidelberg. In that time I saw something over one hundred major operations for various conditions. One is impressed with the many cases of cancer, tuberculosis, gall stones and goitre presenting for operation here. Sixty per cent. of the cases operated were cancer or tuberculosis or gall stones. Not a few of the other forty per cent. were gastric ulcer. I was fortunate enough to see a most interesting case of tuberculous ulcer of the stomach. It was excised, with considerable of the fundus in which it was situated and a gastroenterostomy done with the Murphy button. The latter is the usual technic favored by Prof. Czerny and Prof. Voelker, his assistant. The thyroidectomy done by Czerny or Voelker is very clever. I saw ten cases operated and four that had been done previous to my visit.

Prof. Czerny told me they averaged over a hundred cases of gastric ulcer a

year in the Akademisches Krankenhaus Klinik. There are 214 beds in this surgical clinic and they are full most of the time. This, of course, is independent of the Orthopedic Clinic of Vulpian and the gynecologic clinic of Von Rösthorn. In addition to this interesting surgical clinic I was permitted to be with Prof. Czerny and Prof. Max Jordan, formerly first assistant to Czerny, in their private work. Jordan is a clean, rapid and clever worker and is doing a large practice. I had been with him in 1902, which he was kind enough to remember and he was most gracious to me at this second visit. He does a neat, careful thyroidectomy. He has small hands, is rapid and deft and reminds one much of von Eisselsberg.

Many changes have recently occurred in the clinic and chair of surgery at Heidelberg. Prof. Czerny retired this week to become director of the Cancer Laboratory and Research Clinic just founded there. It opens in October with forty beds. Much is hoped from the work to be done here.

A great fest was given Czerny at the Staats Halle by his colleagues, students and fellow-townsmen one night during my stay. It was a very hearty testimonial in good German style to this celebrated master. Songs, speeches and cheering refreshments were the program for the most of the night. This good old gentleman was on hand promptly for a hard morning's clinic, however, at 9 o'clock the next day, although nothing had happened.

Czerny's successor at Heidelberg is to be Prof. Naroeth of Utrecht, a former student of Bilroth. The retiring professor recommended him. He comes to Heidelberg in October.

My journey to Berlin was broken by stops of several days at the attractive spas of Baden Baden, Wiesbaden and Hamburg, and at Frankfurt, Weimar and Jena. I went to Jena to see Dr. Köhler's ultraviolet light in microphotographic work. Through introduction

given me by Prof. Geo. E. Hale to Dr. Czapsky, I was shown this remarkable illumination whereby the resolving power is increased a hundred fold. Kohler has written an elaborate monograph on his discovery. A special lens is required. It is made by the Zeiss people. I had the pleasure of being shown through the large microscope factory of Carl Zeiss. Sixteen hundred men and fifty women are employed in this great establishment. More than half this number are engaged in the delicate work of lens grinding and polishing. I was

shown a very interesting apparatus for projecting the image of opaque objects on a screen, which should be invaluable for teaching purposes. The University at Jena has 1400 students. After a day at Weimar, visiting the homes of Goethe, Schiller and Liszt, I came to Berlin. After a brief visit to the clinics here I shall spend six weeks at Berne, Lousanne and Paris. I have just dined with Dr. Hibbard and Dr. Church. They are both well and enjoying study here.

A. S. L.

## ELECTRICAL APPARATUS AND THERAPY.\*

### THEIR APPLICATION IN GENERAL PRACTICE.

BY DR. ALBERT SOILAND, LOS ANGELES, CAL.

In response to the kind invitation from your county society, to present a paper for your consideration and discussion, I have taken the liberty to prepare a short article upon that subject which mostly interests me, viz.: Electricity.

While no doubt some of you are more or less indifferent to this matter altogether, or may even look upon all electro-therapeutical attempts with derision, yet I strongly feel that no apology is needed for presenting the same to your attention.

It is not desirable to give a text-book delineation upon the various kinds of electricity and apparatus used. I will rather attempt to discuss this matter briefly, and, if possible, point out such items as I have found practical and of interest in my limited experience with the various electrical agents.

I ask your indulgence for my necessarily incomplete efforts, and will appreciate free discussion and criticisms.

Since the entry of the Roentgen Rays into the medical world, electricity has become of enormous importance, and its use has increased a hundred-fold. The

early workers in electro-therapeutics used, as you know, the Faradic or induced, and the Galvanic or direct currents. Of late these have been largely relegated to the background to make room for the more imposing and elaborate static and high-frequency machines. While I fully appreciate the value of these modern instruments, yet I cannot refrain from commenting that we are neglecting old and reliable assistance which we are far better acquainted with than with the newer and more imposing-looking machinery. There are several reasons for this state of affairs, the chief one being that it is so much easier to place your patient upon an insulated platform or couch, and press the button; no clothing to remove, the big wheels go round, the patient is duly impressed, and gladly pays a good fee (sometimes).

Now, with our old-fashioned Galvanic and Faradic apparatus, the clothing must be removed, wet and disagreeable sponges are required, the mental effect is not nearly so invigorating, and the patient often believes he can buy a battery as good as yours for \$10.00 at the

\*Read before the Orange County Medical Association at Santa Ana, June 5, 1906.



corner drug store, and cure himself and all mankind. Possibly the latter contingency has stimulated our profession to larger machines and display.

The *modus operandi* of the high potential static current and the high frequency resonator discharge, is by no means so clear in our minds as the workings of the Faradic induced, or the Galvanic direct currents. The Faradic is, as you know, a current magnetically induced by a primary cell in a coil of wire. It is a current of comparatively high voltage as wound for therapeutic use, but of low frequency. The interruptions or alterations can be varied mechanically to suit the case in hand. This current, then, is alternating. That is, the positive and negative poles change places as often as the mechanical interruption occurs. These alterations are too slow to give the effect of a high-frequency current, and too rapid to permit of any chemical or polar electrolytic action. Furthermore, the Faradic, or, as I prefer to call it, the magnetic induced, is a current of sensation, and has an affinity for muscular structures. For any muscular incapacity of functional type, or where no nerve degeneration exists, quicker results follow an intelligent application of Faradism, than any other form of electricity. A good example of this action is manifest in the treatment of enuresis. I have succeeded in restoring the tone of the bladder muscles in adults with the Faradic current in several cases where the trouble had existed since childhood.

In electro-diagnosis, the rapid response of normal muscle to Faradic applications, makes this current oftentimes invaluable. The Faradic apparatus that is best suited for general practice, needs by no means be expensive. A coil containing from 2 to 5 thousand feet of secondary wire, is ample, actuated by two to four primary cells. Both rapid and slow interrupting device is indispensable, and some means, either by

Rheostat or Shield, to permit of gradual increase or decrease of current.

Referring now to the Galvanic or direct current, sometimes called continuous, chemical, battery, Voltaic, etc., we note an entire difference, both in mode of action and arrangement of apparatus.

The two forms of direct current employed by physicians, are derived either from a direct generating dynamo, or by chemical action from a battery of primary cells, either wet or dry. Here is a current produced which flows in one direction continuously, and for that reason has a constant polarity. This means that each pole, positive and negative, has a definite and distinct action, and as this action exhibits considerable chemical differentiation in each pole, it behooves us to discuss this current more closely.

When two sponge electrodes attached to the terminal of a Galvanic or direct-current apparatus, are placed in position on a surface of the body, and the switch is closed, the following occurs: The tissues immediately under the positive electrode become contracted, the calibre of the blood vessels is narrowed, more or less sedation occurs, and an acid condition is induced by the collection of oxygen in the active field of this pole. Under the negative electrode, the tissues become congested, from a dilation of the vessels. The part becomes irritable and physiologically inflamed and an alkaline condition supervenes from the hydrogen which collects at this point. If one will bear in mind the distinct action of each pole, when using Galvanism, for a suitable condition, fewer failures will be charged up to this form of electricity. This same polar action can be intensified to destroy tissues, by connection to smaller and suitable electrodes. These are inserted around or into the tissues, and sufficient current is employed to cause chemical decomposition of the lesion treated.

This process is called *Electrolysis*.

The positive pole, from its stringent acid activity, is useful to destroy vascular tumors, naevi, etc. The negative, with its more active, alkaline caustic, will destroy and liquify hard and non-vascular tumors more easily, such as epithelial and horny growths.

In using the needle for electrolysis, one must be careful that it is always attached to the proper pole. The best rule to remember, is, to never use an oxidizable metal on the positive pole, when working on the skin of exposed parts. If this is done, an oxide of the metal will be deposited in the skin, which will remain as a tattoo mark for years. If the positive pole is to be used for the active pole about the face when removing vascular tumors, a pure gold or platinum point must be used. On the negative pole, however, any metal can be attached, and the ordinary, steel, surgical needles are the most convenient.

If at a loss to know the positive from the negative pole, the following test will differentiate the two. Wet a piece of blue Litmus paper, place the cord tips of your battery about a half-inch apart on the Litmus paper, turn on the current. In a few minutes the Litmus will turn red under the positive tip, and more blue under the negative. This proves the positive to be the acid and the negative to be the alkaline pole. If no Litmus paper be had, dip the two cord tips into a glass of water. Turn on the current, and from the negative pole will be seen bubbles of hydrogen arising to the surface of the water. This is caused by the rapid electrolysis of the water.

In making these tests, do not permit the cord tips to touch one another. This is to avoid a short circuit, which is destructive to the cell elements in your battery.

For the physician's office where the direct current supply of 110 volts is available, a wall apparatus can be easily installed. Here the current can be

placed through a serial lamp, to the patient, and together with an ordinary graphite rheostat and milliamperemeter, makes the simplest and best device for general Galvanic work.

A milliamperemeter is absolutely indispensable to the proper administration of the direct current. This is most important, for the resistance of different individuals, and even different parts of the same individual, varies greatly. This is illustrated by placing two electrodes on the skin, and turning Rheostat until meter registers 5 milliamperes. Now, without changing Rheostat, move one of the electrodes to some mucous surface, as the mouth, and the meter instantly shows 15 to 30 milliamperes. Without a meter, it is impossible to tell how much current is flowing. Where no direct current supply can be had, the doctor can rig up 30 to 50 La Clanche cells in series. These make a very satisfactory equipment, and when connected to meter and Rheostat, answer all purposes nicely.

In discussing the value of the static or frictional electricity, it is first necessary to understand the nature and physiological action of this current. The static, as generated by our modern instruments, is primarily a direct current induced by the rapid revolution of glass discs in a dielectric medium. In other words, by the rapid revolution of the discs, a great disturbance of the normal electric level is produced. This results in a high positive charge on one side of the machine, and a low negative charge on the other. When the resulting strain reaches the limit of its endurance a sudden disruption occurs, and we witness the beautiful electric discharge taking place between the conductors. If we now include a milliamperemeter into the static circuit, we note that no deflection of the needle takes place. This tells us that no appreciable amperage is developed, and that therefore the formidable-appearing spark passing must be

harmless in so far as producing dissolution or electrolysis of the human tissues is concerned.

Drawing an inference from this, we can safely say that the action of the static current must be purely physical, for we know that it requires at least one half milliamperes to produce any chemical change in the tissues. The negligible quantity of amperage is compensated for by the tremendous voltage generated, which is sufficient to overcome whatever resistance the patient offers. The necessity of actual contact is eliminated from most static work, which is of considerable advantage also.

What are the effects of an ordinary static application? If the patient be placed upon the insulated platform, with the negative electrode to the feet, and the positive crown from 10 to 12 inches above the head, a 30-minute application, the machine running at slow or moderate speed, will produce decided relaxation or sedation, and in some people drowsiness. This is accompanied by a gentle flow of perspiration and a sensation of wellbeing.

The exact *modus operandi* of the current, in producing these effects, is not quite clear. The sensory impression is very small, merely a cool breeze or a slight, tingling effect on the scalp. Physically, the current passes through the body from head to foot.

If the polar action of a static is analogous to that of all direct currents, which I have reason to believe is correct, we would expect a contraction of muscular tissues in the positive polar field, resulting in lessened vascularity. This would account for the cerebral sedation and drowsiness. On the other hand, the negative polar field, which in this instance, includes practically the entire body except the head, would become relaxed, the blood distributed to the points of greatest resistance, the skin, where the action is more pronounced. Hence the mild perspiration.

If we reverse the polarity, a 20 or 30 minute seance will remove fatigue and cause a feeling of exhilaration, from the stimulating effect of the negative on the cerebral tissues. In this manner, when a gentle sedative effect is desired, the positive terminal should be attached to the head, and where stimulation is sought for, the negative must be substituted. Some authors claim that the Static current accomplishes good by virtue of its power to induce vibratory and electrical changes in the ultimate cells of the body.

The theory is also advanced that in disease, a disturbed molecular arrangement or an inequality in the distribution of the positive and negative electrons exists. If so, we can assume that some corrective influence is given to these deranged cells, whether electrical or metabolic, by the application of the static or frictional current.

There are a number of ways to apply static electricity, both general and local, with which you are no doubt familiar—the general positive and negative insulation, and general oscillatory discharge from the jars, and the wave, or direct potential alternations, which are excellent to produce muscular contractions and to bring on deep stimulation. Then there are the various local sprays for tender areas, and the vigorous sparks for counter irritation and local stimulation.

In the care and management of the static machine, much could be said. Very few physicians are very well acquainted with their machines, and the great majority of them, I am sorry to say, make use of their instruments merely for the psychic effect they can obtain. The best static machines are made in the United States, the two chief types being the Induction Holtz and the Friction Holtz. The induction machine is a very efficient one, and with proper care, does splendid work. This instrument operates without noise. The initial charge is made on a separate ex-



citer plate which is disconnected as soon as the machine generates. The secondary discharge comes by induction from the large plates. The friction machines have no separate generators, the brush and button arrangement being connected to the large plates direct.

While the output from any good-sized friction machine is of course sufficient for all ordinary therapeutic work, the first named induction machines deliver a steadier and more efficient current. I have used different makes of both types of machines, and speak from experience.

The care of static machines is all important. They must be kept clean, and they must be kept dry. The two easiest drying agents to manipulate are calcium chloride and freshly burned quicklime. About once every month or six weeks, a fresh supply of either agent, placed in a wide-mouthed vessel, with the top securely covered with gauze, and kept inside the machine case, will insure good generation of current.

The latest electrical device invented to separate the doctor from his hard-earned cash is the high-frequency apparatus. The different oscillating and resonating high-frequency devices now manufactured are legion. Most high-frequency work done is by means of the glass vacuum electrodes of various designs. These tubes, which are erroneously called Violet Ray Generators, can be excited by any static machine so that a separate high-frequency apparatus is unnecessary. By high frequency is meant a current of alternating polarity, so rapid that we can scarcely conceive the number of alternations per second. They go up into the millions.

Such a current is generated when a high voltage current from a static machine or a Rumkorf coil, is allowed to flow through Leyden jars or a secondarily wound coil. When we place a meter in the bath of a current of this type, we learn that considerable amperage is developed; enough, in fact, to

light up several incandescent lamps. Here, then, is a current differing from the static in amperage, yet with sufficient voltage to overcome all ordinary resistance. At first glance it would seem dangerous to employ a current with enough voltage to penetrate the human body and developing sufficient amperage to light incandescent lamps.

A 16-candle lamp consumes 1-2 ampere, which, pushed by a direct current of sufficient voltage, could produce electrolysis and death.

The safety of the high-frequency current lies in the extremely rapid alternations. In other words, the polarity changes so infinitely many times per second, that time is not given for electrical dissolution or polar action, and therefore the current can be used with impunity.

The general action of the high-frequency current simulates the static. The former is probably more active in its effect upon nutrition and metabolism than the latter. The popular method of general high-frequency treatments is by means of auto condensation and auto conduction, also using a large resonator, by which the patient is placed in tune with the electrical oscillations of the generating apparatus. Locally, the effluve, as the high-frequency discharge is called, is also a little more active than the static spray, and is used for practically the same conditions. Any physician who wishes to, can, without much trouble, construct a device which, when attached to the static machine, gives a good high-frequency effect. A battery of from two to six Leyden jars can be covered with tin foil or wound with magnet wire; mount sliding rods, and a spark gap over the last two jars, and you will have a painless spark effect of the effluve.

In France, chronic eczema and other skin diseases are treated by this electrical modality with success.

As before stated, this paper is brief, considering the subjects covered, and of necessity incomplete.

If I have been successful in pointing out to you the largeness of the present

field of electro-therapy and its possibilities, if entered into by liberal-minded and conservative physicians, my efforts in preparing this little article are well spent.

## EXTRA-UTERINE PREGNANCY.

### REPORT OF THREE CASES.

BY MARK A. RODGERS, M.D., TUCSON, ARIZONA.

Case I. Mrs. R., aged 33. Family and personal history negative. One child aged four years. Menses always regular and normal. Missed one period and about three weeks thereafter was seized with severe cramps in lower left hypogastrium with vomiting. This attack lasted about two hours when the cramps and vomiting ceased and the conditions returned to the normal. No physician was consulted. The following day went with her husband for a drive in the country where after a lunch was again seized with cramps and vomiting which after an hour or two again subsided. On returning to the city I was consulted at my office where after a careful examination I was unable to arrive at a definite diagnosis although the probability of an extra-uterine pregnancy was suggested. The woman being of large physique and somewhat obese, bimanual examination was necessarily negative.

The following morning at two o'clock I was summoned by telephone to the patient's apartments in a local hotel where I found her in a state of profound shock which had developed following another attack of cramps. At this examination the abdomen was soft and relaxed, pulse slow and rather weak, face pale and pinched. Vaginal examination absolutely negative. Patient vomited once.

A diagnosis of ruptured pregnancy was made and permission asked to remove the patient to the hospital for operation. This was declined and con-

sultation requested. Two consultants were called one of whom concurred in my opinion and agreed that operation was imperative; while the other demurred and gave it as his opinion that the patient was suffering from peritonitis and that operation would ultimate fatally. The husband unfortunately followed the advice of the advocate of non-interference with the result that the patient died the following morning. Autopsy showed the abdomen to be full of blood and a ruptured pregnancy in the outer third of the left Fallopian tube. There were no adhesions. Comment on this case is unnecessary.

Case II. Mrs. M., aged 24. Suffered from rheumatism for a number of years during which time she contracted the morphine habit. Patient also had a mitral regurgitant murmur and had almost expired two years previously during the birth of her only child. At this time, during labor, there developed extreme cyanosis accompanied by a pulmonary hemorrhage which lasted until delivery of the child, when a profuse postpartum hemorrhage relieved the venous engorgement and spontaneous resuscitation occurred after apparent dissolution had taken place.

At this time patient reported having missed one menstrual period and believed herself to be about eight weeks pregnant. From my previous experience with this case I did not hesitate to explore the uterus which I found empty. Under chloroform anesthesia a considerable mass could be felt in the left pelvis which I took to be an ectopic

pregnancy. Operation was decided upon and the patient removed to St. Mary's Hospital, where she developed a severe attack of peritonitis during the preparation for operation. As soon as the process, which was evidently septic became walled off and the symptoms of invasion began to subside, the abdomen was opened and a tubo-ovarian foetal mass about six centimeters in diameter was removed together with the left tube and ovary, the latter containing an abscess in which was about two ounces of pus. There were numerous adhesions. The right tube and ovary although normal were also removed.

Following the operation the patient did very well for about a week; then sank into a stupor and remained comatose for exactly one month. Fortunately the coma was at no time so profound that the patient could not be made to swallow when fluids were poured into her mouth, thus preventing death from exhaustion. However, after a prolonged and weary convalescence during which time the patient was insane, complete recovery took place. The patient is now a normal and healthy member of society.

Case III. Mrs. M., aged 36. Family history negative. Personal history: mother of four children. After having gone two weeks past her normal men-

strual period was seized with intense cramping pains in the lower right hypogastric region. I was called in consultation with her regular medical attendant about two o'clock in the morning and found the patient resting easy after a hypodermic injection of morphine.

Examination at this time was entirely negative save for a slightly accelerated pulse. At 8 o'clock, a.m., I was again called and found pronounced evidence of hemorrhage, with rapid pulse, extreme pallor and seizing respiration. I advised immediate operation and operated at once in the hallway of the patient's residence, the abdomen being opened in one-half hour after the second consultation. There were about two quarts of fluid blood in the abdomen and after the removal of the ruptured sack with the right tube and ovary great difficulty was encountered in controlling a very profuse hemorrhage which oozed from the foetal attachment on the floor of the pelvis. This was finally controlled with a gauze pack. The convalescence was uneventful.

All of these cases occurred in my practice within one year. Undoubtedly there would have been three recoveries had I been permitted to operate on Case I.

June 5th, 1906.

## OUR DUTIES AS CITIZENS IN THE PREVENTION OF TUBERCULOSIS.\*

BY GEORGE H. KRESS, M.D., LOS ANGELES, CAL.

The Southern California Antituberculosis League exists because the State has a tuberculosis problem to solve. This tuberculosis problem in turn owes its origin to California's climate. "But," it may be said, "California's climate is inimical to the spread of tuberculosis." True. "How, then," may be asked further, "can it create a tuberculosis situa-

tion that may be termed a menace to the public health?"

These would be the natural questions which would suggest themselves to a stranger, when told the seemingly inconsistent facts, that California has a climate decidedly unfavorable to the spread of tuberculosis, and yet at the same time a death rate from the great

\*Read before the Annual Meeting of the Southern California Antituberculosis Society, San Bernardino, May 1st, 1906.



white plague higher than that of any other State in the Union.

We who live here know why this condition of affairs exists; know that it is because of this same favorable climate that scores and scores of consumptives come hither from the East, unfortunately, however, in the great majority of instances, in such advanced stages of the disease and in such a low state of finances, that living from necessity under worse conditions than in the East, any other outcome than death is quite out of the question for them. All that many of these unfortunate sufferers gain is a prolongation of life for a few months. Some do not even accomplish this.

To deny our climate to these fellow-creatures who have contracted a disease which exists largely because of our own negligence in matters of hygiene and modes of living, would mean that we would be forced to establish a state quarantine against consumptives, and a state quarantine against eastern consumptives would not only be an inhumane measure, but would be impossible to enforce. State quarantine is an evidence of blind, cowardly, ignorant fear, and can have no advocates among those who look at this problem rationally and intelligently.

Yet, while it is true that we should not deny the advantages of our climate to these sufferers from the East, the East, on the other hand, should make an effort to understand how to prescribe and use our climate. When the East sends a poverty-stricken consumptive to us, who not only is unable to supply himself with his material needs so that it is necessary for Californians to support him, and who in addition, because of the nature of his disease, infects his surroundings and so endangers the lives of the citizens of this State, the East commits a crime for which it may justly be ashamed.

The East should learn, that, though Southern California has a dry, well-

drained soil, an atmosphere with an abundance of oxygen, a maximum number of sunny days in the year, a difference between day and night temperatures to be mildly stimulating, a general topography pleasing to the eye and restful to the mind and body, all these forming a combination of climatic factors which are not only inimical to the development of tuberculosis, but favorable to its cure, that other elements than these are necessary, if a consumptive is to have a decent chance to regain his health and prolong his life.

He cannot live on the air and sunlight alone, since these, indeed, only improve his appetite and necessitate an increase in expenditure of money. He must possess means to enable him to purchase nutritious food in ample amounts, and further, to provide himself with lodgings that will enable him to breathe the California air, both night and day. The consumptive should not be obliged to work, but should be able to give himself up to the one task of getting well with his whole heart, soul and mind. In short, he should lead, under careful guidance, the proper mode of life, in a pleasant and suitable environment.

Yet it is safe to say that fifty to seventy-five per cent. of the consumptives who come to us from the East fail to do these things, and because of this failure on their part, and more especially because of their poverty-stricken condition when they come here, we of California are brought face to face with a problem that not only means added financial burdens, but which bids fair to become a serious menace to the public health of our section of the State, unless we adopt measures that will rob the presence of these consumptives of these dangers which always exist wherever tuberculosis is widespread.

A consumptive is dangerous, virtually, because his sputum or spittle may contain in twenty-four hours not only millions, but billions of the germs which

cause disease, and these germs can live for months in damp, dark places. Yet you need not worry greatly when you see a consumptive spit into the street. The sunlight and oxygen of the air will render such sputum innocuous and innocent in a few hours or days. We do not need anti-spitting ordinances for our public highways nearly so much as we need anti-spitting ordinances for our homes and lodging-houses, nor nearly so much as we need building ordinances that will prevent the erection of unsanitary, unhygienic and poorly ventilated buildings and rooms. We need much more than anti-spitting laws for the public highways, ordinances also that will make lodging-house proprietors maintain clean establishments, and that will necessitate the periodical fumigation of hotels, lodging-houses and second-hand establishments.

We need, in short, a system of compulsory registration and fumigation, so that our health officers could prevent ignorant or vicious consumptives from infecting their surroundings and so becoming a source of danger to the public health of our people. From the same humanitarian principles then, that should keep us from closing our State to the tuberculosis unfortunates from the East, we should insist that once among us, they should observe such precautions as will prevent their presence here from being a danger to the citizens of this commonwealth. All we ask is that the sputum shall be expectorated into suitable receptacles, and that this expectoration shall be burned or otherwise destroyed, and that the apartments in which consumptives live shall be periodically fumigated. These things we would accomplish if possible without physical hardship or mental distress to the victims of the great white plague.

Compulsory registration of all cases of tuberculosis (meaning by this, confidential notification of the health officer by the physician of every case of tuberculosis with which the physician comes

in contact, no placard or sign being placed on the house, and no visit being made to the patient, unless the attending physician states that sanitary conditions are bad), is one of the most, yes, in the speaker's mind, the most urgent of all our needs in the prevention of tuberculosis. Only through compulsory notification can you learn where the persons who have the disease live, and this knowledge is absolutely necessary if we are to make a thorough and comprehensive attempt to destroy the germs that spread the disease. If we are to reach the germs, it is necessary to know where the people live who produce the germs. No method other than compulsory registration will give us this absolutely essential and fundamental knowledge.

This system of compulsory registration implies that the physician obligates himself to instruct his consumptive patients how to render the sputum harmless, and includes, as already stated, the periodical fumigation of rooms occupied by consumptives, and of hotels, lodging-houses and second-hand establishments. With compulsory registration of tuberculosis established, other hygienic, preventive and curative measures will follow as a natural sequence.

To recapitulate: The Southern California Antituberculosis League has as one of its objects of being the prevention of the spread of the great white plague among our people. Present conditions favor the spread of the disease among our citizens. Now, it is ethically as much of a crime to kill a citizen by allowing him, through negligence of proper sanitary laws, to become infected by a preventable disease like tuberculosis, as it is to go out on the streets and kill him with a pistol or knife. It is our plain duty as citizens to inaugurate measures that will prevent eastern consumptives whom we cannot prevent entering California, from becoming a source of danger to the public health of the State. A system of compulsory registration and fumigation as

briefly outlined would mean a tremendous stride forward in the direction of real prevention, and as the method has been most successfully tried in our own and European countries, we not only urge you to give it your thought and aid, but more than that, since this tuberculosis problem of Southern California affects every one of us, to do your civic duty by agitating the necessity of compulsory registration and fumigation, not only for your own

community, but for the entire State. In the speaker's mind, there is no preventive measure that can offer anything like the large number of beneficent results as can these methods that strike at the very fountain head of all the danger; and we are undoubtedly negligent of our civic duties and responsibilities when we fail to give this work our earnest co-operation.

390 Wilcox Bldg.

## DEPARTMENT OF DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M.D., EDITOR.

### EDITORIAL COMMENT.

**NECESSARY REQUIREMENTS FOR INTELLIGENT INFANT FEEDING.**—After carefully following out the methods that we detailed in this journal two months ago, it is well to ask ourselves when we may consider that the bottle-fed baby is thriving.

Increase in weight is the best indication of the correctness of our formula, although none of us consider an infant with a very large deposit of fat as necessarily a healthy specimen; in fact, the baby of average weight is apt to be a healthier infant than the one who is overweight. We decide, then, upon the color, the weight, the development, and a general air of well-being. If for a week or even more the gain is not quite up to the standard we need not be discouraged, nor need we be too hasty to change our percentages. In a month the average gain may be normal, as bottle-fed babies often gain irregularly.

We should change the formula as little as possible. We must remember that the bottle-fed baby is taking at best an imperfect substitute for the mother's milk, and it is well to let the parents understand this. Many infants are constipated, the same formula may in different children be attended by one or two normal daily movements, or there may be, in another child, obstinate con-

stipation, with hard scybalous masses. The milk feeding is not always at fault, a certain number are constipated from gut inertia, and others from a lack of secretion of the succus entericus and the normal lubricating fluids, to use a homely simile; others seem to inherit a tendency to constipation from the mother. In order to correct constipation it is well to omit heating the milk; sterilized milk should also be omitted, and if possible to obtain a clean milk, it should be given raw, or at least but slightly Pasteurized. It may be necessary to increase the fat in the formula, but here we again sound a note of warning; a too high fat percentage will produce symptoms probably more annoying than the constipation which we were trying to overcome.

In infants and young children do not increase the fat to over 3 or 4 per cent. More than this will cause spitting or rejection of the food after nursing, and curds will be ejected from time to time between the feedings, the vomitus is sour, and much gas is expelled by eructations. We must reduce the fats or serious vomiting may result, a more dangerous symptom by far than constipation.

A cautious and proper increase of the fat will often correct constipation; instead of diluting the top milk four



times, for infants up to three months, we may dilute it only three times, and thus slightly increase the fat. While thus increasing the fat, we must be alert to detect a fat-diarrhoea. While the infant is thriving, we may find that the movements become fluid and yellow in color, they may even become oily in consistence; then there will be some abdominal distress and colicky pains. These movements, which are normal in color and contain no curds, but have an oily consistence, clearly show that we are giving fats in excessive quantity. It is well then to suspend all food for a few hours and then start with a reduced fat percentage mixture. We must remember that some infants will take the high fat percentages and give no evidence whatever of fat-diarrhoea.

A low percentage of fat also has its attendant evils. If this is continued for two or three months, the infants will not gain in weight, will be constipated, and suffer many disturbances of nutrition. This applies to a percentage that is maintained below 1.5 per cent.

Spitting or rejection of food in a breast-fed infant does not give as much cause for anxiety, but not so with a bottle-fed baby. Here it may be a precursor of serious enteric disturbances, when the food must be suspended almost entirely. The spitting may be due to too high fat content, and although the child is thriving, we should gradually reduce the fat until the spitting ceases. In the mean time the percentage of proteids is not to be interfered with.

So also may breast-fed infants have frequent attacks of colic without giving us any anxiety, but again this is not so with artificially fed infants. The breast-fed baby often thrives under these conditions, and the movements appear to be normal, but the bottle baby with colic always makes us worry. It indicates that the digestion of the proteids in our mixture is not carried out in a normal manner.

Faulty proteid digestion is attended by much colic and an alteration in the consistence and color of the movements, with curd particles, or even large white curds, or the movement may be a thin yellow fluid, mixed with white curds.

We must reduce our proteids, but they must not be too low. A one-month-old infant should have not less than 0.8 to 1 per cent of proteids, one of three months, 1 to 1.5 per cent. of proteids, and one of six months 1.5 to 2 per cent. of proteids. These percentages presuppose that we are dealing with normal children, but we will find, even at the sixth month, those who cannot digest 1.5 per cent. of cow's proteids. These we must place on a one-per-cent. mixture; less than this will cause a diminished gain in weight, although the infant may be more comfortable, with less colic and more normal stools. We must work between 1 and 2 per cent. and find out the amount that can be comfortably digested by each infant, but never allow the proteids to reach too low a percentage.

Bottle-fed babies who are doing well, gaining weight, and are in every way satisfactory, will from time to time have greenish movements, mixed with white curds; the next movement may be perfectly normal. This may persist at intervals for a week or two, and we rarely give the matter any attention, but if these movements occur frequently and are accompanied by colic, the milk is not digested because the proteids are in excess and must be modified.

If a bottle-fed baby vomits a portion of its food once or perhaps twice daily, but does not seem much disturbed by it, increases in weight, looks healthy and its stools are normal, it is well to let well enough alone, in spite of the solicitation of the young mother to have us do something. The only thing that is advisable to suggest is a slight reduction of the food at each feeding.

If the child continues to vomit and

does not increase in weight, it offers one of the hardest problems in percentage feeding, and we will consider it more fully at a subsequent time; suffice it to say that as a rule stationary weight or loss of weight means that the proteids have been reduced below the safe limit. If this is persisted in there is great danger of malnutrition, scurvy or a malignant type of rickets. So also will a too low fat percentage prevent gain in weight, but remember that a too rapid increase or a too high fat percentage will give rise to food spitting and rejection, and later gastro-intestinal symptoms, terminating in fat-diarrhoea. This illustrates how difficult our problem is.

Another puzzle is the child, newborn or a young infant, who thoroughly assimilates the proper mixture, but fails to gain in weight. These little patients sleep well, eat well, digest well, and pass a normal movement, but they do not gain in weight. If we increase the fats and proteids the mixture will disagree, and we are on the other horn of the dilemma.

## REVIEW OF THE LITERATURE.

FOR PURE MILK. — Milk commissions usually have a primary and a secondary purpose. The primary purpose is to meet whatever demand there is or may develop for a milk of exceptional cleanliness, produced under its direction and examined by its agents, the commission having no financial interest in the sales aside from necessary expenses. Moreover, these expenses, such as those incident to the inauguration of the work, may be borne as in Cleveland, by philanthropic men.

The secondary purpose of commissions is to improve the general milk supply by education of the public as to the desirability of clean milk for every one and its necessity for infants, and education of the producer in the methods of its production.

Milk commissions have everywhere

attained a degree of success in their secondary purpose. That Cleveland's commission is no exception to the rule is indicated in several ways.

The health code of the city, which as to its regulations of the milk supply, was written since the organization of the commission, embodies most of the rules known to be necessary for the production of a high-grade milk. That the directions in this code must be considered educational and advisory rather than obligatory, must, we think, be conceded. If followed, the directions should result in a milk of about the quality of the "inspected milk" of the New York Commission.

An additional indication of the educative or supposed educative effect of the commission may be seen in the claims and advertising put forth by dealers since its organization.

We have already called attention to the claims of a dealer who adopted the copyrighted term "Certified" as a part of the firm name during the time the commission was organizing, and who has at various times claimed that his milk was actually certified by the commission, although on one occasion, at least, an examination by the city bacteriological laboratory showed it to have a very high bacterial count.

A further indication of the educative effect of the labors of the commission may be found in the advertising used by those firms which employ this method of publicity. Some of these larger dealers have been glad to aid in the distribution of certified milk, and physicians are indebted to them for their present ability to secure this milk in practically every part of the city without the trouble and expense of special messenger delivery. Therefore, in commenting upon their advertising we must not be thought unappreciative of their public service. As compared with certified milk distributed in a score or more of wagons, an ordinary milk business of equal volume would be distributed from

one or two wagons in a relatively small area, and could not be distributed to the entire population with a profit.

As the provisions of the health code have approximated the regulations of the commission, so has also the general tone of milk advertising. Every encouragement should be given those who are trying to furnish a milk of improved quality, and we do not wish to imply that the firms upon whose advertising we are commenting are not trying, for self-preservation as well as for other reasons, to give their patrons a better and more satisfactory milk. Fulfillment, however, does not always keep pace with promise.

Physicians need more complete knowledge of the conditions surrounding the production of pure milk so that they may be able to scrutinize with intelligence the claims of those who are supplying this greatest of necessities to the infants and invalids under their care. Finally, when physicians order what is in their opinion the best milk, they should not rest content, but see that it is received. It is stated, for instance, that distributors of certified milk have tried, occasionally with success, to persuade prospective purchasers of certified milk to take their milk instead. Further, patrons of these dealers, using milk for the feeding of infants, have complained to them of the poor quality of the milk they were receiving and, willing to pay any price for good milk, have not had certified milk called to their attention. The dealers, of course, deny any knowledge of such occurrences.—*Editorial, Cleveland Med. Jour., May, 1906.*

## REVIEW OF BOOKS.

### KOPLIK ON DISEASES OF CHILDREN.

A Treatise on the Diseases of Infancy and Childhood. For Students and Physicians. By Henry Koplik, M.D., Pediatricist to Mt. Sinai Hospital, ex-President American Pediatric Society, etc., New York. New (2nd) edition. Revised and enlarged in text and illustrations. Octavo, 868 pages, 184 engrav-

ings and 33 plates. Cloth, \$5.00; leather, \$6.00 net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1905.

Twenty-five years ago the number of books in the English language devoted specially to the study of children, or the present more fashionable study of pediatrics, could be counted on the fingers of our hands, and those that have survived the test of time can be counted on a smaller unit. Latterly many books have been written on the general subject of pediatrics, and not a few have to do with more special and minute subdivisions of this special work. Some of these will live, a few have been epoch-making, and represent the awakening interest in the child and its diseases. Koplik has given us a book which we think will survive the test of time. That it is appreciated at its full worth is evidenced by the early demand for a second edition which has given the author an opportunity of bringing the work abreast of the advances of the past few years, an opportunity which has been well improved.

The section on infant feeding is clear, strong and up to date. The recent and striking advances in this most important branch of pediatrics all receive full consideration.

The chapters on the Physiology and Pathology of the new-born are more full and complete than is usual in works of this sort.

The methods of examination and history taking are to be highly commended. The many advances in our knowledge in the specific infectious diseases, more particularly typhoid fever and meningitis, have received careful notation, and place the reader fully *au courant*. Throughout the book one receives a succinct reflection of the pediatric knowledge and practice of the present day. The volume is increased by nearly two hundred pages, and a number of original illustrations have been added.

The best surgeon is one who is also a very good physician, and so with the physician, he is the best who has a good



working knowledge of surgery, at least knowledge enough to know when a condition is surgical and demands immediate surgical judgment. We are glad to see that Koplik has adopted the plan of our *Cyclopedia of Diseases of Children*, and that of Ashby and Wright, in covering both the medical and surgical pictures in studying and treating diseases of children. They so overlap that a book on pediatrics which is either purely medical or purely surgical has a limited field of usefulness.

There is so much to commend in this book that we are a little surprised in reading the chapter entitled Hypertrophic Pyloric Stenosis; while the etiology, morbid anatomy and symptoms are in accord with the modern views, the treatment seems curiously at variance with these views. It does not reflect the up-to-date exposition of our knowledge. We have available about fifty-five autopsy records of infantile pyloric stenosis treated medically, and in all a pyloric tumor was present, unassociated with adhesions of any sort, and the enlargement in every instance was due to a hypertrophy of the circular muscular fibers. The interesting point is that the picture in the dead house is the same picture on the operating table.

The pyloric stenosis has been found in the living, in every instance by the surgeons. Koplik has seen three cases in which the history, symptoms and physical signs were undoubtedly those of congenital stenosis, and all recovered without operation. This is not our experience, and we feel that in later editions the author will modify this statement, when these so-called recovered cases are studied longer, as there is evidence to show that infantile forms of stenosis may persist to adult life, and then become annoying as chronic stomach disturbances. Maier and Lauderer have recently, in *Virchow's Archives*, vol. vii. p. 413, clearly shown this to be a fact. In the face of a medical mor-

tality of about 88 per cent. it is hard to understand why Koplik should say that with these weak infants every expedient should be tried before resorting to surgical intervention. Surgery has thirty-two recoveries and twenty-eight deaths as its record, a recovery percentage of 53.1-2 per cent. What has medicine to offer? A mortality of 88 per cent. and the probability that the other 12 per cent. will come to the operating table later in life for chronic pyloric stenosis, after years of unnecessary suffering and serious invalidism.

If the following words, taken from the treatment of intussusception, page 500, were made to apply to pyloric stenosis, the above criticism would not hold: "The diagnosis of intussusception once made, the case is one for surgical interference. The sooner surgical treatment is begun, the better the chances of recovery." So we repeat, the diagnosis of pyloric stenosis once made, the sooner surgical treatment is begun the better.

The reviewer has nothing but commendation for this excellent book. We owe the author a great debt for his masterly presentation of the entire subject.

W. A. E.

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It is said that *alum given in lead colic* will relieve pain, nausea and constipation, and is one of the best remedies to be used for this purpose. Bartholow claimed that its action was dynamical, and that it would overcome the relaxation and paresis of the muscular layer. To a pint of boiling milk add ninety grains alum powder; separate the curd, and an ounce of sugar to sweeten may be used if desired. A wineglassful may be taken every hour.

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For two weeks before the expected date of birth give your primipara half an ounce of ol. ricinii every other night; labor will be a dream.

## DEPARTMENTAL

## DEPARTMENT OF TUBERCULOSIS.

CONDUCTED BY F. M. POTTINGER, A.M., M.D., PROFESSOR OF CLINICAL MEDICINE, MEDICAL DEPARTMENT OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

**EARLY BACTERIAL DIAGNOSIS OF TUBERCULOSIS.**—The clinical study of tuberculosis in recent years has advanced our knowledge of this disease very materially. What was formerly considered to be an early diagnosis is now known to be a far-advanced condition. In the struggle for mastery of this malady, clinicians and bacteriologists have tried to find new methods and new signs by which the disease might be detected at the earliest possible moment. After the discovery of the bacillus the microscope was relied upon almost exclusively for the diagnosis, and in this way we were able to detect the disease much earlier than we had been wont to do; but this spurred on the clinician, and he soon found that he could detect tuberculosis very often long before bacilli were found in the sputum. Many specialists in tuberculosis today take the ground that the bacteriological diagnosis of tuberculosis is not an early diagnosis at all; and they give as their reason that you cannot have bacteria in the sputum until you have had destruction in the tissue, thus showing an advanced stage of the process. We also hear the bacteriologists claim that if you examine the sputum with sufficient care, that you will find bacilli long before you can detect the disease by the ear. The facts of the case are that, ordinarily, if a man has a well-trained ear, he will be able to detect tuberculosis in the lung while it is a closed process, before the advent of the tubercular bacilli in the sputum, providing the area of involvement is sufficiently large; however, for a man who is not able to examine so critically, the chances are that he might have large areas of involvement and still not be

able to recognize the alterations in the breathing. It seems to me that it is our duty to use every method of value at our command. We must remember that is possible to have so small an area of involvement that we might have a breaking down and an escape of bacillus-bearing sputum, and yet the process be so small, or be so situated, as not to be detected by the ear.

Regarding the microscopical examination, everyone knows in what a haphazard way this is usually done. It is not at all uncommon to find one single slide, made from a single sample of sputum, and if no bacilli are found, to have the patient informed that tuberculosis is not present. In many of these cases if a number of slides were made, not from one sample of sputum but from different samples of sputum, bacilli would be found and a diagnosis established bacteriologically.

Blume, in the *Berliner Klinische Wochenschrift*, No. 29, 1906, calls attention to the importance of careful bacteriological examination. In cases where incipient tuberculosis was suspected, he has examined the larynx and wiped off particles of mucous found in the larynx, and by examination of these particles he has been able to detect tuberculosis very often, even where the patient showed no expectoration. He calls attention to this as being a very important matter, and suggests that this line of procedure be followed in all cases where tuberculosis is suspected. He tells of a number of cases where he has been able to make the diagnosis in this manner. Doubtless if such care were exerted in our taking of samples of expectoration for examination, we might be able to verify our diag-

nosis very much more often than we do.

In early diagnosis there is one thing that is very important, and that is, to be able to convince the patient that your diagnosis is correct. These patients are always skeptical because they feel so well. They do not feel that it is possible for them to have so serious a disease with so few symptoms. If the careful examination of the secretion coming through the larynx will help to fortify one in his diagnosis, it is well worth the trial.

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PROGNOSIS IN TUBERCULOSIS.—Rumpf, *Munchener Klinische Wochenschrift*, No. 29, 1906, made a critical study of the patients from the Sanatorium Friedrichsheim with reference to prognosis, the summary of which is as follows:

He makes the basis of his study 990 patients who were treated in 1900 and 1901, there being four years since the period of treatment.

Of these, 541 or 54.7 per cent. were still able to work, 108 or 10.9 per cent. were unable to work, and 341 or 34.4 were dead.

Of the 990 patients, 281 were in the first stage.

Of these at the end of four years, 248 or 88.3 per cent. were still able to work, 18 or 6.4 per cent. were unable to work, 15 or 5.3 per cent. were dead.

There were 265 in the second stage, of whom at the end of four years 183 or 69 per cent. unable to work, 33 or 12.5 per cent. unable to work, and 49 or 18.5 per cent. were dead.

There were 444 in the third stage, of whom 110 or 24.8 per cent. were able to work, and 57 or 12.8 per cent. were unable to work, and 227 or 62.4 per cent. were dead.

Considering these 990 patients from the standpoint of age, there were 152 patients between the ages of 16 and 20 years, of whom 94 or 61.8 per cent. were able to work, 6 or 4 per cent. were

unable to work, and 52 or 32.2 per cent. were dead.

There were 216 between the ages of 26 and 30 years, of whom 147 or 59.8 per cent. were able to work, 24 or 11.1 per cent. were unable to work, 65 or 30.1 per cent. dead.

There were 172 between the ages of 31 and 35 years, of whom 98 or 57 per cent. were able to work, 25 or 14.5 per cent. were unable to work, and 49 or 28.5 per cent. were dead.

There were 108 between 36 and 40 years, of whom 45 or 41.7 per cent. were able to work, 15 or 13.9 per cent. unable to work, and 48 or 44.4 per cent. dead.

There were 92 between the ages of 41 and 50 years, of whom 46 or 50 per cent. were able to work, 15 or 16.3 per cent. were unable to work, and 31 or 33.7 per cent. dead.

There were 19 over 50 years of age of whom 4 or 21.1 per cent. were able to work, 8 or 42.2 per cent. were unable to work, and 7 or 36.8 per cent. dead.

This shows that the early years, between 16 and 20 offer the best prognosis as far as ability to work is concerned, after the period of four years.

Of these 990 patients there were 334 that showed a family history of tuberculosis; of these 176 or 52.7 per cent. were able to work, 42 or 12.6 per cent. were unable to work, 116 or 34.7 per cent. dead.

It must be remembered that Brehmer believed that the later children in a family, especially those after the fifth, were not as strong as the first children. Of these 990, 187 would fall in this category.

Of these 113 or 60.4 per cent. were still able to work, 19 or 10.2 per cent. were unable to work, and 55 or 29.4 were dead.

The effect of accelerated pulse upon prognosis is often mentioned. Among these patients 461 showed an accelerated pulse; of these 145 or 31.5 per cent. were



still able to work, 54 or 11.7 per cent. were unable to work, 262 or 56.8 per cent. dead.

Of the patients who had fever at the beginning of the disease 171 lost their fever. Of these there were 71 or 41.5 per cent. still able to work, 22 or 12.9 per cent. unable to work, 78 or 45.6 per cent. dead.

Of those who did not lose their fever during the treatment there were 157 who still had fever on discharge. Of these there were 9 or 5.7 per cent. still able to work, 8 or 5.1 per cent. unable to work, 140 or 89.2 per cent. dead.

There were 75 who showed tuberculosis of the larynx. Of these 5 or 6.7 per cent. were still able to work, 6 or 8 per cent. unable to work, and 64 or 85.3 per cent. dead.

To show the effect of the seasons upon treatment, the patients were grouped according to whether they were treated in the summer time or the winter time.

There were 506 treated in summer time, of whom 282 or 55.7 per cent. were unable to work, 172 or 34 per cent. dead.

There were 484 treated during the winter, of whom 259 or 53.5 per cent. were still able to work, 56 or 11.6 per cent. were unable to work, and 69 or 34.9 per cent. dead.

Rales had disappeared entirely from the chests of 308 patients, of whom 276 or 89.6 per cent. were still able to work, 18 or 5.8 per cent. were unable to work, 14 or 4.6 per cent. dead.

Fine crepitant rales were still heard in 356 chests at the time of discharge. Of

these 223 or 62.6 per cent. were still able to work, 53 or 14.9 per cent. were unable to work, and 80 or 22.5 per cent. dead.

Moist rales were to be heard in 326 chests upon discharge. Of these 42 or 12.9 per cent. were still able to work, 37 or 11.3 per cent. were unable to work, and 247 or 75.8 per cent. dead.

The average time of treatment of these cases, it must be remembered, was not very long. These cases were treated at the expense of the insurance companies, and, as a rule, the average period of treatment is about three months. Of course many of these cases would have required a much longer time in order to have brought about a cure; and there is no doubt but had they been treated for a clinical cure instead of an economic cure, a much greater per cent. would have been alive at the end of the four years. We think, however, that the result is very good, and points to the hopefulness connected with the treatment of this grave disease.

These statistics are very interesting because they include a sufficient number of cases to be of some value.

I would like to call special attention to the effect that a rapid pulse has upon the prognosis. We have often pointed out that the heart is one of the most important organs to be considered in tuberculosis, and we have insisted upon the fact that this organ must be spared in every way possible during treatment. Over-exercise cannot help but be harmful, and prolonged over-exercise very often tells upon the heart and reduces the chances of living.

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## DEPARTMENT OF INTERNAL MEDICINE.

CONDUCTED BY DUDLEY FULTON, M.D., LOS ANGELES.

**PYURIA THROUGH LEUCOCYTOSIS.** — Talma (*Berliner Klinische Wochenschrift*, May 28, 1906) says that it is possible for pyuria to exist as a true infection of the blood without any

demonstrable portal of entry of the invading organism. He says that the pneumococci, for example, may be found transported by the blood stream to almost any part of the body without the

development of pneumonia, and streptococci may give rise to septicemia without localized suppuration. He describes two cases of pyuria in which he considers that the kidneys served as excretory organs for the pus present in the blood without themselves being the seat of an actual suppurative inflammation.

Examination of the urine in these cases showed that not only pus cells, but also pus serum had passed through the kidneys. In the one case examination of the blood showed 43,000 leucocytes with 94.4 per cent. of polynuclears, and in the other three were 17,000 leucocytes, with 79 per cent. of polynuclears.

\* \* \*

**HAEMOPHILIA.**—Prof. Sahli gives, in the *Zeitschrift f. Klin. Medizin*, some observations on four recent cases of Haemophilia. The examination of the morphological constituents of the blood showed only slight deviations from the normal. The amount of fibrin was within the limits of health.

Ordinarily, haemophilic blood requires double the normal time for coagulation. When, however, the bleeder has been bleeding for some time, his blood coagulates more quickly under the same conditions than from a normal person, especially so, when the blood is removed from the site of the hemorrhage.

Sahli found that the addition of defibrinated normal blood brought about much quicker coagulation in haemophilic blood. As a very small amount of the former was effective, a ferment—"Thrombo-Kinase"—is suggested as being the essential, lacking in haemophiles. Sahli believes that this is normally secreted in amounts sufficient to prevent excessive hemorrhage from the injured walls of the blood vessels.

About treatment, he considers the best and only means for lessening the tendency to bleeding is plenty of mixed diet and bodily exercise. For injuries, a 2 per cent. gelatine dressing, or

a 1-2 per cent. solution of calcium chloride, but he sets his hopes upon the local use of adrenalin. He condemns the use of perchloride of iron and injections of ergotine.

\* \* \*

**TRANSPLANTATION OF THYROID GRAFTS INTO THE SKIN IN MYXOEDEMATOUS CONDITIONS.**—Thyroid therapy has long been known to be partially effective in conditions in which there is insufficient secretion of the gland. But the treatment is only palliative and there is a possibility of a tolerance being established so that the therapeutic effect is lost.

Many attempts have therefore been made to transplant portions of the thyroid gland under the skin, but unsuccessfully—until lately.

Charrin and Christiani (*London Lancet*) have recently employed a great many very small portions of the glands, taken from animals of the same species and transplanted with great celerity.

At a recent meeting in Paris they showed a young woman who, after having received 38 thyroid grafts in two operations was able to greatly reduce the previous thyroid indication. She has, moreover, become the mother of a healthy infant, and during pregnancy the thyroid grafts became enlarged, just as happens with the thyroid gland in pregnancy under normal conditions. The thyroid grafts have preserved their glandular nature.

This case seems to point the way to a new method of treatment.

\* \* \*

**TETANY AND STRUMIPRIVA.**—Recently at the "Gesellschaft für Innere Medizin" in Vienna, Leischner showed an interesting case in connection with the thyroid gland. The patient is a male, aged 40, who was operated on by Billroth, 1890; who removed both sides of the gland, but left the isthmus. Three days after the operation typical tetanic cramps commenced, recurring two or three times a week. Shortly after this the hair be-

gan to fall out, succeeded by a new growth; along with this the nails fell off, and have done this annually since the operation. Marital desire has ceased and he has an objection to all flesh meats.

In the course of time, the isthmus which was left began to increase in size, with a corresponding diminution of the tetanic attacks; but recently the attacks have returned with more severity, now being accompanied with unconsciousness. Thyroid therapy gave no relief to the patient. Some time ago he suffered severely from pains in the legs, followed by cataract of both eyes, for which he was successfully operated on. It is evident from these phenomena that the epithelial bodies of the gland must either have been injured or removed in the operation.

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Authorities agree that *only a small amount of salt is essential to health*, and that amount is approximately 2 to 5 gm. The majority of people take from 10 to 20 gm., and those with the "salt habit" take 30 to 40 gm. The theory of Widal and Juval was that when there is a retention of sodium chloride, the salt retained in the tissues requires a certain amount of water to maintain proper molecular concentration, and dropsy results. This explanation of the cause of edema in nephritis is a plausible one. There is apparently a fixed relation existing between the intake and output of sodium chloride for each healthy individual. Observations thus far indicate that in diseases of the kidneys which are associated with edema, the amount of sodium chloride ingested should not exceed 2 gm. per diem, and that intravenous and subcutaneous injections of normal salt solution should be avoided as a therapeutic measure in all such cases.—*Boston Medical and Surgical*.

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Gray has found *salicylate of iron* (*Edinburgh Med. Jour.*—*N. Y. Med.*

*Jour.*) acts as a powerful febrifuge without first producing diaphoresis. In fifty cases of erysipelas the first or second local application was followed by a fall in temperature and cure in about thirty-six hours. The mixture employed consisted of one drachm of soda salicylate, dissolved in two ounces of water. To this was added two drachms of tincture of perchloride of iron, half a drachm of chlorate of potash, half an ounce of glycerin, and water to make eight ounces. Of this mixture two tablespoonfuls were given every three or four hours. In two hundred and fifty cases of tonsillitis he had similar rapid success. Iodine in weak solution was gargled, while the tincture was applied externally, in addition to the use of the salicylate. It was also effective in croupous pneumonia, in puerperal sepsis, and in various other inflammatory conditions.

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ALCOHOL DRESSINGS. Brugger (*Deutsche Med. Wochenschrift*) advocates the use of permanent alcohol dressings for the relief of pain, inflammation and suppuration of all kinds. The dressings must be thick and kept moist, but not wet, with alcohol. A bag of fine sawdust has been used with good success by Villbrecht; this fits the parts like a soft cushion and keeps moist for about twenty-four hours. The pain and inflammation rapidly subside, and the general effects are good. Alcohol dressings are useful alike to the hospital surgeon and the general practitioner. There are no disadvantages save the trifling and evanescent puckering of the skin, which soon disappears, and the danger of fire.—*New Albany Med. Herald*.

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From five to ten drops of castor oil given frequently during the day is suggested by Delafield as almost specific in the treatment of that *intractable form of diarrhoea* in which there are two or three loose movements in the early morning.



# SOUTHERN CALIFORNIA PRACTITIONER

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Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

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## EDITORIAL.

### DR. NORMAN BRIDGE ON SLEEP.

Our colleague, Dr. Norman Bridge, recently read before the annual meeting of the Association of American Physicians a most interesting paper on "Some Truths About Sleep," the article being printed in *The Journal* of September 1st, pages 652-655.

Some of the points made by Dr. Bridge in his paper are as follows:

That the widely varying views concerning sleep, its causes, and the effects of lack of sleep indicate erroneous knowledge of the subject.

That insomnia, a condition intimately associated with present-day strenuousness, and treated only too often with harmful chemical soporifics—an irrational mode of therapy—this insomnia is not so much the cause of the nervous state of the day following, but is itself a co-result of some prior or more fundamental etiological factor, itself responsible

for both loss of sleep and the bad feelings of the next day.

That to attribute the horrors of insomnia to lack of sleep was to place the cart in front of the horse, as it were. The horrors of insomnia arose not so much from inability to sleep, as from the fear of being unable to sleep.

That our theory that we went to bed to stay there eight or ten hours to obtain sleep was wrong. Sleep was an incident connected with the chief aim, which was rest of the body.

That it is not necessary that children or infants have as much sleep as is generally supposed.

That people become sleepy, more because their bodies are fatigued or their digestive system out of order than because their brains are tired.

These few paragraphs give one an insight into the nature of the paper, in which our colleague wades into some of

our once popular idols in the way of views on this subject.

The topic is one of interest, and be it also said, of considerable obscurity. Physiologists generally acknowledge the impossibility of scientifically accounting for the periodicity of sleep, a plausible explanation being that the brain cells, unlike those of the glands and muscles, not being able to obtain rest in the same sense that gland and muscle cells obtain rest between periods of activity,—a stage is finally reached, when because of this lack of rest the brain cells become less responsive to external stimuli, and as at this time we favor rest by going to bed and shutting out external sounds and stimuli, the condition of unconsciousness known as sleep is induced.

Now whether this lack of irritability on the part of the cortical area of the brain is induced by the brain cells using the oxygen of their protoplasm more rapidly than it can be replaced, so that, as Pflüger affirms, the lessened oxidation reduces their irritability; or whether the accumulation of acid waste products, as the lactic and sarco-lactic acids from the activity of the muscular and nervous tissues, finally benumbs the sensibility of the brain cells; or whether Duval and others are in the right when they contend that sleep is induced by the dendritic processes of contiguous and associated neurons withdrawing their points of contact, or to put it otherwise, by having their contact broken by the interposition of neuroglia tissue; or whether Howell is correct in his view that the vaso-motor center in the medulla, from prolonged activity, becomes less sensitive to stimuli, so that it has no

longer the power of properly regulating the blood supply of trunk and extremities, in that manner bringing about an anaemia of the brain, which in turn induces the unconscious state referred to as sleep—no one seems to know.

But that by the term sleep is meant a condition of the nervous system wherein a greater or less degree of unconsciousness is induced for a considerable amount of each day, and that this unconsciousness is characterized by a peculiar periodicity, on this we are generally agreed.

To our point of view, Dr. Bridge in his paper lays too great stress on the need of rest of the tired body, and we cannot accept his statement that the body tissues generally need horizontal rest more than the cortical area of the brain needs the unconsciousness of sleep and its associated rest. Surely the mostly highly chemically organized tissue of the body and the tissue that performs the most delicate and complicated of all functions needs rest as much as the grosser tissue types. Do not the nerve elements stand as it were on almost constant guard, but do not the muscle-fibers have periods of real rest, even the constantly-acting heart providing for this need in its diastole? And do not the gland cells also seem to have an abundant opportunity to rest?

Is not the victim of insomnia right when he attributes his unnerved condition of the following day to be largely due to lack of sleep? Does not this lack of sleep, implying a non-resting condition of the brain cells, induce a functional derangement of those cells, so that the patient next day feels bad generally?

Is not sleep itself a phenomenon of

the nervous system, and are not the bad after-effects of insomnia largely the result of an irritability occasioned by lack of rest or recuperation in the cortical area of the brain? And is it not, then, logical to assume that the bad after-effects of insomnia are to be more largely attributed to lack of rest of the brain rather than to lack of rest of the remainder of the body?

Dr. Bridge's contention that infants and children do not need as much sleep as is generally supposed, we also find difficult to accept. Man is only a type of animal life, and may we not learn a lesson from the manner in which the young of the lower animals spend so large an amount of their early life, in sleep? Is it not really a fact that many infants and children suffer for years because foolish parents, through improper feeding, or dress, or desire to "talk with the baby," kept them awake when they should have been sleeping?

These few excerpts and comments on Dr. Bridge's article should suffice to show that he has not written a paper on routine lines. It was a pleasure to us to go through it, and we commend its perusal to our readers.

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#### THE SOUTHERN CALIFORNIA ANTI-TUBERCULOSIS LEAGUE.

Under the above caption, in reference to an article on "Our Duties as Citizens in the Prevention of Tuberculosis," by a California contributor, and which is printed in the current number of the *PRACTITIONER*, the *New York Medical Journal* of August 18th prints the following editorial remarks:

"There are many things that might

reasonably be expected to go without saying. Not a few of them, however, need to be said, and said insistently. Among them are the things that Dr. Kress of Los Angeles says in his article entitled 'Our Duties as Citizens in the Prevention of Tuberculosis' (see pages 331 *et seq.*). It was read at the recent annual meeting of the Southern California Antituberculosis League, and, since we do not doubt that its humane tenor represents correctly the purposes and methods of the league, we hope that its publication will strengthen the hands of that organization.

"California has often and in manifold capacities been entitled to look upon herself as a general benefactor. We may be sure that California does not on that account meditate any falling off in good works. She recognizes that it is more blessed to give than to receive, and she is quite alive to the significance of the old fable of the belly and the members. She realizes that God did not make the climate of her southern section for her sake alone. She knows that it is the duty of every State and of every lesser community to work for the welfare of the nation and for that of the world. She will not shirk this duty, but certainly she is entitled to look for reciprocity and to insist that the rest of the country shall not burden her with its paupers or its moribund.

"No harm can come to California from the decent and orderly settling of consumptives within her borders, but no argument is needed to show that it



is injurious to the State that there should swarm upon her soil from the East consumptives unable to provide themselves with the necessities of life or so palpably stricken with death as to have become incapable of observing ordinary sanitary precautions or been rendered viciously disposed to disseminate their disease. In short—and the same may be said of other health resorts—California, placing her salubrious conditions at the service of outsiders who are in need of them, has a right to demand of those outsiders a decent regard for her own welfare. She asks no more, and we cannot in fairness put her off with less. We count on seeing the Southern California Antituberculosis League achieve a great work in furthering the rational management of tu-

berculous disease, and not in California alone, for the league's influence for good will be felt in many another community."

To Californians this expression of recognition by an eastern medical journal, of the dual responsibility necessary to the care of the country's indigent consumptives is very gratifying, and is in line with the practical efforts made by the Charity Organization Society of New York to make physicians realize their personal responsibility in sending consumptives far from home without adequate funds.

With the advent of eastern sanatoriums and a recognition of what the open-air life really means, still further progress along this line may be hoped for.

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## EDITORIAL NOTES.

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Dr. C. W. Girdlestone of Riverside took his vacation at Oceanside.

Dr. S. S. Salisbury has been taking his vacation at Lake Tahoe.

Dr. T. E. Cunnane, of Ventura, has been spending his vacation at Tahoe.

Dr. W. W. Roblee of Riverside spent his vacation at Idyllwild.

Dr. David B. VanSlyck of Pasadena has been recuperating at Catalina.

Dr. Titian James Coffey of Los Angeles has been seriously ill.

Dr. A. A. Libby of Pasadena is making an extensive tour through the East.

Dr. Adolph Kramer, the San Diego oculist, has been spending a few weeks in Idyllwild.

India this year produced 8,560,000 tons of wheat.

Dr. A. G. Rounseville, of Williams, Arizona, is spending a few weeks in the east.

Dr. A. W. Vanneman, of Hermosillo, Mexico, is spending a few weeks in Los Angeles and vicinity.

It is now proposed to erect a modern sanatorium in Long Beach, Cal., to cost \$150,000.

Dr. C. N. Bledsoe of Bisbee has been spending a few weeks in Southern California.

Dr. I. S. Gwaltney of San Pedro has returned from an eastern trip.

Dr. Gayle G. Moseley of Redlands is doing hospital work in New York City.

Dr. R. S. Lanterman of Los Angeles was recently seriously injured in an electric car collision.

Dr. F. J. Nutting of Searchlight has been relieving mental strain by playing bridge-whist in Los Angeles.

Dr. Charles S. Harris, after an absence of some weeks, has returned to San Bernardino and resumed practice.

Dr. S. S. Salisbury of Los Angeles has returned from his vacation at Lake Tahoe.

Dr. George Carlos Sabachi of Los Angeles has been summering at the Potter Hotel, Santa Barbara.

Dr. J. M. Radebaugh of Pasadena has recently been visiting his old home, Gettysburg, Pa.

Dr. Elger Reed of El Monte, Los Angeles County, has been doing post-graduate work in Chicago.

Dr. J. H. Seymour of Los Angeles has practically recovered from a serious illness.

Dr. R. Nichol Smith of Los Angeles has been spending his vacation in Idyllwild.

Dr. Coyle J. Tracy of Pasadena has been appointed a member of the insanity commission of Los Angeles county.

Dr. James H. Shults of Los Angeles has been taking an extended tour through the east.

Dr. Woods of Santa Rita, New Mexico, who recently arrived from an eastern trip, is quite ill.

Peppermint is grown most extensively at Kalamazoo, Mich. The crop in America last year was 300,000 pounds.

Sicily produces 500,000 tons of sulphur annually, or 80 per cent. of the entire production of the world.

The United States produces this year 800,000,000 bushels of wheat, and 2,713,194,000 bushels of corn.

Dr. J. W. Alexander of Needles, Cal.

has been taking a vacation in Los Angeles.

Dr. Niel C. Trew of Highland Park, Los Angeles, has returned after a month's vacation.

Dr. A. S. Parker of Riverside was recently called professionally to San Francisco.

Dr. A. C. Hart of Sacramento, a member of the State Board of Examiners, has been visiting friends in Los Angeles.

Dr. Martin Regensburger, one of the distinguished physicians of San Francisco, has recently taken a hurried trip through Southern California.

We have already had the "disbarred lawyer," the "suspended clergyman," and now we are to have the "delicensed physician."

Dr. Georges Clemenceau, today the leading statesman in France, was before the Franco-Prussian War a practicing physician in New York City.

The engagement is announced of Dr. Arthur M. Smith, Police Surgeon of Los Angeles, to Miss Helen B. Milligan of Chicago.

Dr. Henry Herbert has removed his offices to the Grosse Building, corner of Sixth and Spring streets, Los Angeles.

Dr. Arthur Savage of Pasadena was married on August 15 to Miss Janette Voorhees of Kewanee, Ill., at the residence of the bride's parents.

The Ventura County Medical Society held its regular meeting on Monday evening, August 6, at the office of Dr. R. D. Potts, Oxnard, Cal.

Dr. F. P. Whitehill of Silver City, New Mexico, has recently been spending a few weeks in the New York hospitals.

Dr. Rose T. Bullard of Los Angeles warns people against kissing babies on the lips. She says "It is liable to, and

in many cases does, result in the spread of infectious disease."

The last week in August a cablegram was received from Dr. John R. Haynes showing that he was having some warm experiences in the city of Moscow.

At the regular monthly meeting of the Santa Barbara County Medical Society, held in the Chamber of Commerce, the subjects discussed were "Cross Eyes" and "Floating Kidneys."

Dr. C. C. Browning of the Pottenger Sanatorium, Monrovia, Cal., has been touring the East and also making a ten day's trip through the Yellowstone Park.

Dr. A. Morgan, the Coroner of San Diego County, is again a candidate for that position. He graduated from the Medical College of the University of Michigan in 1881.

As showing how low a normal pulse rate may be, it is stated that the pulse of Napoleon Bonaparte was normal at 32. A well-known banker of San Diego has a normal pulse rate of 42.

Dr. D. S. McCarthy, so well known in Los Angeles, is at Alamo, Mexico. He is in excellent health, and looks forward to being again with his friends in Los Angeles.

The Port of Baracoa, Cuba, exported last year 18,500,000 coconuts. The cocoanut trees are planted twenty-eight feet apart and they begin to bear in about five years. Some of the best trees are over fifty years old.

We regret very much that our distinguished friend, Dr. E. S. Solly of Colorado Springs is quite ill at the "Virginia" in Chicago. We trust that Dr. Solly will soon be restored to his professional work.

Dr. H. M. Voorhees, who was for five years connected with the California Hospital at Los Angeles, is now the resident surgeon for all of the hotels in Yellow-

stone Park. The doctor will return to Los Angeles the first of October.

Dr. Hoell Tyler of Redlands is spending a few weeks in New York City. Having spent eleven years of his professional life in New York City, the doctor has the entree to everything that he may desire to see.

The next meeting of the Mississippi Valley Medical Association will be held at Hot Springs, Arkansas, November 6th, 7th, 8th. Communications regarding papers should be addressed to the secretary, Dr. Henry E. Tuley, 111 West Kentucky street, Louisville, Ky.

Dr. Joseph Jauch of Los Angeles was recently married to Mrs. Mary A. Hotchkiss, a millionaire widow of the Angel City. They sailed from New York on August 21st, and will remain in Switzerland, the doctor's native country, for some months.

They are now oiling the streets in Liverpool in order to lay the dust. Several varieties of oil and oil preparations were used but crude petroleum gave the most lasting results, and portions of the road heavily coated with this oil shows a somewhat glazed surface formed of oil and dust.

The Iowa legislature is expending \$35,000 per annum to increase the yield of corn in that State by five millions of bushels. The plan adopted is one of education, experts going to every farmer in the State to teach him the best method of selecting seed corn and of planting and cultivating.

Dr. John Love of Ventura, died on July 21st and his funeral was held July 24th. The pallbearers were Dr. D. W. Mott, of Santa Paula, Dr. W. R. Livingston of Oxnard, Drs. Bynum and Stockwell of Ventura. The Doctor was a great-hearted, generous man, thoroughly beloved by all who knew him.

Dr. A. E. Wagner, recently from Philadelphia, has located in Downey, Los Angeles County, and succeeds Dr.



Q. J. Rowley, who has been the leading practitioner in that town for twenty years. Dr. Rowley will take a well-deserved rest and then locate in Los Angeles.

Dr. John Miller Wilson and Miss Laura Edith Loughhead were married in Pasadena on August 15th. After a trip east they will be at home to their friends at No. 56 North Euclid avenue, Pasadena. Dr. Wilson is a graduate of the College of Physicians and Surgeons of Chicago.

The engagement is announced of Dr. Robert P. McReynolds, of 3722 Walnut street, Philadelphia, to Miss Frances Coulter of Los Angeles. The bride is the daughter of a multi-millionaire merchant of Los Angeles. Dr. McReynolds graduated from the Medical Department of the University of Pennsylvania in the class of 1895.

Dr. Dudley Fulton of Los Angeles writes the PRACTITIONER that he has been in Vienna for six weeks, after having spent a little time in Berlin. He will return to Berlin in about five months. He says Vienna certainly lives up to its reputation as a great place to study internal medicine. His address is still IX Kinderspitalgasse, Vienna, Austria.

The English are taking vigorous measures to stop the use of tobacco, especially cigarettes, by boys and girls under sixteen. Their plan is to find the one who sells and also the child in possession of tobacco or cigarettes, and place the child under the jurisdiction of the Juvenile Offenders' Court.

Dr. Herbert F. True has just returned from two years' post-graduate work abroad, putting in much of his time in the eye and ear hospitals of London. The Doctor will be the resident physician at Idyllwild until the close of the season, and will then occupy offices in the Auditorium Build-

ing, corner of Fifth and Olive streets, Los Angeles.

Dr. Walter Sydney Johnson of Los Angeles and Dr. Julia Ross Younglove of Boston were married on August 15 in Riverside. The bridegroom is aged 34 and is a native of Minnesota. Some years ago Dr. Johnson came to Los Angeles under an agreement with Dr. Younglove that when he had built up a practice here she would leave her home in Boston and come to Southern California to become his wife.

The *London Times* asserts that genuine dairy butter is a thing past praying for. Four-fifths of the population of London, the *Times* says, have never seen it in their lives. What is called genuine butter in London, the *Times* says, is blended and reworked butter. Its tough, tenacious texture is as different as possible from that of real dairy butter, and it is destitute of the subtle aroma of the unworked butter.

Dr. F. C. Shurtleff is president and Dr. G. A. Scroggs is vice-president of a "Vaquero Club" who have secured a ranch near Los Angeles and erected a club house thereon. The first bullshead breakfast was held on the morning of July 22nd. The menu consisted in part of three bullsheads, a large amount of beef and roasting ears.

The Gulf of California is alive with Sea Bass, Red Cod, Red Snapper, Cuttle Fish, Sole, and several other species. Whales, such as the Hump-back, are abundant, and occasionally a few sperm and bottle nose; also common seals, and the large black fish which is sought for its oil. Turtles, both green or common turtle, and the fine hawk-bill, which produces superior tortoise shell, are also found.

Dr. F. C. E. Mattison of Pasadena has returned from an interesting eastern trip. As he came home he stopped in San Francisco to see the ruins. He was in the city at the time of the earth-

quake, stopping at the St. Francis, and all of his baggage was destroyed. He had not been back since the fire and he says the scene now is much more pitiful than it was at first. "Now the desolation of the city has settled down upon it and with the cooling of the ashes come the cold, hard facts of a bitter reality." He said he could not bear to stay and see it.

The castor bean of the American commerce is grown exclusively in a small area in Oklahoma, eastern Kansas, western Missouri and Southern California. British India supplies almost the whole world with the castor bean. Castor beans were found in the sarcophagi of the ancient Egyptians, and records of the utility of the plant are found in the earliest writings of the Hindus. In China castor oil is used as a cooking grease, the same as lard in the United States. In British India it is used as an illuminant in lamps. Over 1,000,000 gallons of castor oil are used annually in the United States alone.

Dr. Robert W. Craig of Phoenix recently paid a visit to Los Angeles. He had a pass on the railroad, and when the conductor came through the car the doctor was accidentally overlooked; so in order that the poor conductor might have his records all correct the philanthropic doctor called him back and said: "You forgot to take my ticket, here it is." The conductor took the pass and cast one glance at it. "Doctor, this is the limited train; passes are no good on this train." Then the doctor had to pay his fare like any ordinary man. It is said that Dr. Craig will no longer claim that honesty is the best policy.

At the last meeting of the State Board of Examiners it was resolved that hereafter the board hold three examinations annually; one on the third Tuesday of June in Los Angeles, the second on the third Tuesday of September in San Francisco, and the third on the third Tuesday of December in San Francisco.

It strikes us this is an ideal arrangement. First, Southern California gets one annual examination; second, this examination is at a date that suits the graduating classes of the Southern California medical colleges; third, the ensuing interval to December is six months—the period required by law, instead of eight months, for those who fail. The fourth great advantage is that the whole board will be present at each examination.

The *Los Angeles Daily Times* of August 26th said: "The California State Board of Medical Examiners have just concluded the semi-annual examination at the State Normal building. Dr. Dudley Tait of San Francisco was the only examiner present from the north. The following graduates of the College of Medicine of the University of Southern California were successful in the examinations, and will receive their licenses to practice medicine from the State board early in September: J. T. Ball, W. Barnhart, H. H. Chamberlain, I. Crowell, C. W. Decker, F. B. Dwire, F. D. Fairchild, E. F. Kinne, C. C. Ledyard, E. G. Mattison, E. E. Patton, J. T. Perry, C. Phelps, W. J. Reed, K. R. Sleeper, H. Smith, H. A. Thompson and E. M. Wellcome."

Dr. J. A. Colliver of Los Angeles is doing post-graduate work in the Vanderbilt Clinic, Sixtieth street and Amsterdam avenue, New York City. He is there to do special work in children's diseases. He is working daily in Dr. Holt's Clinic, three mornings a week in the Babies' and Children's Hospitals, and the rest of the time at the Hospital for Ruptured and Crippled and the Post-Graduate Hospital. In all of his spare time he is assisting Dr. Le Fetre, editor of the Archives of Pediatrics, and chief of the children's and babies' clinics classifying the cases at the Vanderbilt Clinic—some 20,000. As chief of the medical clinic at the College of Medicine of the University of Southern California, Dr. Colliver is studying the system of

every department in the Vanderbilt Clinic, even to the drug room.

The *London Times* says that recent experiments in England of an invention by Mr. Kundsén, a Dane, furnish liquid air at one-sixth of the present market price, and give promise of the low price of a fraction over two cents per gallon. The result is secured by purely mechanical means, without an atom of added chemicals. Atmospheric air is first purified and then compressed by stages to 2500 pounds to the square inch. It is finally reduced to 125 pounds to the square inch, which then cools and liquefies the high-pressure air. One gallon of liquid air equals 128 cubic feet of oxygen gas, which retails at 6 cents per cubic foot. By the new process oxygen and nitrogen can be separated from liquid air and sold retail at \$1.20 per gallon. Liquid air is used successfully in maturing liquors and in the preservation and purification of milk.

Dr. B. M. Smith of Gardena sends us the following interesting communication entitled "WHAT WAS THE CAUSE OF DEATH?"

"GARDENA, CAL.

"To the Editor:

Some time ago I was called to see an infant, age 2 months. The grandmother said she had given 5ii of Castoria at one dose at 12 midnight or about that time. At 3 a.m. she was awakened from a sound sleep by the baby screaming with pain, and symptoms of spasms coming on, such as twitching, jerking, etc., and the baby was vomiting and stools very frequent (about every fifteen minutes and of a watery character). When I reached the house, about 10 a.m., I found the baby still suffering pain and a great deal of tenderness over bowels; face drawn and emaciated; watery bowel movements about every fifteen or twenty minutes; vomiting. The child

would not take anything at first, but after a while it took both food and medicine. I told them it would not live but a few hours and so I gave some bismuth powders and we used some hot applications over abdomen. It died at 1 p.m. quietly, and they said it did not suffer any an hour after I left. I should add that the legs were drawn up (on the abdomen) and the head drawn backward, and the twitching was still going on when I last saw it. It looked like 'cholera infantum,' but after being told of the Castoria treatment I said nothing more about diagnosis. I would be pleased to hear the opinions of others.

"B. M. SMITH."

Dr. Paul Allen Adams has arranged an anaesthetic blank which he uses in all cases in which he gives an anaesthetic. The blank is filled in as the operation progresses, and at the conclusion is given to the patient's nurse to be copied onto the chart or filed with the bedside notes.

The report is of special value to the surgeon in that it assists him in forming an opinion as to the patient's condition following operation by informing him accurately how long the patient was under anaesthesia, the length of the operation, the kind of anaesthetic and the amount used, and the kind of stimulation, if any, required.

The blank used is arranged as follows:

*Report of Anaesthesia.*

Los Angeles, Calif.....	
Name .....	
Anaesthesia begun...Stopped...Time...	
Operation begun...Stopped...Time...	
Anaesthetic .....	Amount.....
.....	Amount.....
Medication .....	
.....	
<i>Anaesthetist.</i>	

Bryonia is of special value in the coughs of pneumonia and bronchitis.



# TWENTY-ONE YEARS AGO IN LOS ANGELES.

EXCERPTS FROM THE SOUTHERN CALIFORNIA PRACTITIONER, VOLUME I, NUMBER 9, SEPTEMBER, 1886.

"In most cases of consumption, before it is possible for the stethoscope to reveal the pathological change in the lungs, or the microscope to show the specific bacillus of phthisis, certain conditions are present which cause the patient more or less distress, and should always receive the serious attention of the physician. These phenomena are, for the most part, dependent upon imperfect assimilation of food and the consequent malnutrition.

"Indigestion and dyspepsia are usually the earliest symptoms recognizable. . . .

"The gastric disturbance varies in character. . . .

"It is not to be understood, of course, that every person who dislikes fat will have consumption; but, in nine cases out of ten, where the aversion to fat exists in a person whose family is consumptive, phthisis may be expected to appear sooner or later, and the hereditary predisposition to consumption may be exhibited not only in parents and grandparents, but also in brothers and sisters, uncles, aunts and cousins. In 60 per cent. of all cases of phthisis, the hereditary taint may be traced. (See article, "The Hereditary Transmission of Pulmonary Consumption," *Cinti Lancet and Clinic*, Jan. 24, 1885.) . . .

"Another phenomenon which should excite the physician's suspicion is the loss of weight in the patient. . . .

"A third symptom, which is sometimes observed early, depends only partially and indirectly on malassimilation, viz.: increased rate of respiration. . . .

"These three symptoms which I have briefly described—indigestion of some form, loss of weight, and increase in rate of respiration, usually accompanied by diminished expansion of the lungs—are

important alike to patient and physician; because in a great many instances they constitute the earliest indications of the incipient pathological changes, which at first are too minute to be recognized even by our most perfect appliances. They are the advance guard which give warning of a dangerous enemy's approach; by observing them carefully the experienced physician learns the character of the threatened danger, and by prompt attention may avert the attack, or at least greatly modify its dangers and severity."—*Excerpt from an original article entitled "Some of the Earlier Symptoms of Consumption," by John L. Davis, A. B., M. D., Los Angeles, Cal., Lecturer on Materia Medica and Therapeutics in the Medical College of the University of Southern California.*

\* \* \*

"We look upon intubation as being a new mode of treatment, but ever since the time of Hippocrates have tubes been introduced into the larynx with various objects in view. . . .

"To Dr. O'Dwyer, of N. Y., belongs the credit of again bringing this operation into use and perfecting it, so that it is indorsed by many of our best practitioners.

"In the latter part of 1882, or early in 1883, he began working on this subject, and up to the 21st of February, 1885, no public notice was given of it."—*Excerpt from an original article by Will E. Lindley, M. D., Los Angeles, Cal., Demonstrator of Anatomy in the Medical College of the University of Southern California.*

\* \* \*

"Just now, in the warm weather, when the popular panacea for all ills that flesh is heir to is a daily or twice

daily plunge in the surf, a word of caution may not be amiss. . . .

"The objects to be accomplished by bathing are in the main included under five headings:

1st. Cleanliness.

2nd. Increasing the sudorific or sweating action of the skin.

3rd. Lowering bodily temperature.

4th. Relaxing the system.

5th. Giving a tonic shock to the system. . . .

"Cleanliness is one of the virtues of civilization, but a virtue carried to excess may become almost a vice. There is a safe mean to all things. Remember the old Latin adage, *in medio tutissimus ibis*.

"Mothers of feeble infants, invalids, at home or going to the seaside, less water and more oil! And thou mayest, perchance, wax fat, and kick thy heels at lean and wasting disease."—*Excerpt from an editorial entitled "Be Clean! Be Clean! Be Not Too Clean!"*

\* \* \*

"Our return trip from San Diego to Los Angeles was over the California Southern railroad. After leaving San Diego proper we soon passed through Oldtown. This was formerly San Diego, but is now almost a deserted village. Yet with its fig, palm and orange trees, adobe buildings and Mexican inhabitants it is certainly picturesque. A fellow passenger pointed out the ruins of an isolated adobe, and said that was San Diego's first jail. It cost the county fifty-five thousand dollars, and its first and only inmate was the contractor who built it. He was imprisoned for fraud, and the first night knocked one of the walls down and escaped. . . .

"We liked San Bernardino surroundings very much. All of the suburban places looked so homelike and thrifty. High, snow-capped mountains are very few miles away, and many people in mid-summer go up into these mountains in-

stead of going to the coast. At Colton we met Dr. G. L. Hutchinson (Long Island College Hospital), who came to Colton with phthisis, and is now hard at work and believes himself well."—*Excerpt from an editorial on "Riverside and San Bernardino."*

\* \* \*

"Dr. Will E. Lindley read a paper on Intubation, that appears in full in the PRACTITIONER.

"Discussion on Intubation.

"Drs. Shoemaker, Follansbee, Davis, Card, Walter Lindley, McCarty, all spoke hopefully in regard to the operation.

"Drs. Lathrop and McGowan did not believe it would supplant tracheotomy.

"Society adjourned to meet first Friday in September in Dr. McGowan's office."—*Excerpt from "Proceedings of Los Angeles County Medical Society."*

\* \* \*

A young physician, who has just established himself, and has very little practice, is noted for his braggadocio. One of the older physicians, meeting him on the street yesterday, asked him how he was coming on. "I've got more than I can attend to," was the boastful reply. "I had to get out of my bed five times last night." "Why don't you buy some insect powder?" asked the old doctor.—*Exchange Note.*

\* \* \*

"Professor (to class in surgery)—'The right leg of this patient, as you see, is shorter than the left, in consequence of which he limps. Now, Mr. Sorter, what would you do in a case of this kind?'

"'I'd limp, too.'—*Exchange Note.*

\* \* \*

"Who is your doctor?"

"Doctor! I don't want any doctor. My neighbor has one, and when he comes I listen at the door to get the prescription free. No doctor for me."—*Exchange Note.*

## MISCELLANEOUS.

## OUR READING.\*

BY DR. C. J. K. JONES, LOS ANGELES  
PUBLIC LIBRARY.

Recent essays and criticisms on books and reading have dwelt much upon the use or profit, the "Cui Bono" as it were, of the practice of reading on the one hand, and the misuse of reading—e. g. Mr. Frederic Harrison, the superlative master of our English tongue, as he is, also of the art of fine criticism of books, belongs to the school of the men who would have us always ask the question, when we take up a book, to what use or profit does the book tend. He would have us judge books as we would the character of their author. He very rightly says, in effect, a book can be no greater than the intellectual and moral character of the man, or woman, who wrote it. A great work of literature is the product of the greatness of some element in the mental or moral make-up of its author.

Harrison therefor insistently, and incessantly, preaches against the neglect of the books with the suffrages of the world's most intelligent judges have pronounced great, substituting therefor the little books whose principal recommendation is their current popularity, or the element of singularity which is their sole recommendation. Harrison carries his rule to an extent of rigidity that is extreme. Reading as such he declaims against. Sir Arthur James Balfour, on the other hand, maintains that reading for knowledge is necessary, and that reading for pleasure is one of the chief enjoyments of the intellectual man.

Harrison is the chiefest apostle of the school who favor the old books which are great. He regards, as I shall show later, the present enormous output of the press as an evil scarcely mitigated by the good wrought by the books

and authors he praises. His plaint as to books, constantly reiterated, is "Non multa sed multum." "The incessant accumulation of fresh books must hinder any real knowledge of the old." "It is impossible to give any method to our reading till we get nerve enough to reject." His supreme question is, "What are the books, that in our little remnant of reading time, it is most vital for us to know?" His answer is, "The poetic and emotional side of literature is the most needed for daily use." . . .

If I say that our reading should consist principally of literature, perhaps I would express what men of the two great divisions of intellectual tastes would assent to.

The question will immediately arise in your minds, "What is literature?" I know of no better definition than that given by John Morley, the premier of English biographers, who says: "Literature consists of all the books where moral truth and human passion are touched with a certain largeness, sanity and attraction of form." It is, "a proper instrument for a systematic training of the imagination and sympathies, and of a genial and varied sensibility." "Literature is one of the instruments, and one of the most powerful instruments for forming character, for giving us men and women armed with reason, braced by knowledge, clothed with steadfastness and courage, and inspired by that public spirit and public virtue of which it has been well said that they are the brightest ornaments of the mind of man."

"But after all, the thing that matters most, both for happiness and for duty, is that we should strive habitually to live with wise thoughts and right feelings. Literature helps us more than any other studies to this most blessed companionship of wise thoughts and feelings." . . .

\*Excerpts from an address read before the University Club of Los Angeles, June 14, 1906.



Of course the foundation stones of all literature are the "Classics," which the great French critic, Sainte Beuve, has defined. Speaking of the author, he is one "who has enriched the human mind, who has really added to its treasure; who has got it to take a step further; who has discovered some unequivocal moral truth, or penetrated to some eternal passion, in that heart of man where it seemed as though all were known and explored, who has produced his thought, or his observation, or his invention under some form, no matter what, so it be great, large, acute, and reasonable, sane and beautiful in itself; who has spoken to all in a style of his own, yet a style which finds itself the style of everybody,—in a style that is at once new and antique, and is the contemporary of all ages."

Such authors

"Loose the leash of sweet content

With which mankind is tied;

They bring us out of bygone ways;

They guide us through the dark."

In all this subject of what the people read, it is to be recognized that people's intellectual tastes are very much like their physical appetites, of which it may be said, "*de gustibus non disputandum.*" The evidence of this can be found not only in the circulation of every public library, but, also, in every home library where people are supposed to spend their money for something worth while. When it comes to the purchase of the semi-luxuries of life—as books are generally regarded—people often belie their intelligence as they do their education and literary taste.

"The ten best sellers" are of far more interest to the large majority of patrons of our book stores and public libraries than are all the books of science, philosophy, history, travel and biography that are published. Not one-tenth of one per cent. of the patrons of our Public Library have read, or will read, Duncan's New Knowledge or Clark's

Modern Cosmogonies, whose wonderful revelations of some of nature's hitherto hidden ways have such an illuminating and inspiring effect upon the mind of the intelligent reader.

And even of the higher grade of fiction, my experience is that its sale is limited to a few who know.

On the commercial side of their really great intellectual interest in books, booksellers could tell you of their surprisingly large sales of what I call purely ephemeral books—*books*, I say, not literature; for often they are as much corrupters of a true literary taste as are the current periodicals, than which scarcely anything could be worse, excepting it may be the "penny dreadfuls" of some London news-stands.

We are suffering from a vitiated reading habit. Harrison has well said: "Assuredly black night will quickly cover the vast bulk of modern fiction—work as perishable as the generations whose idleness it has amused. It belongs not to the great creations of the world. Beside them it is flat and poor. Such facts in human nature as it reveals are trivial and special in themselves, and for the most part abnormal and unwholesome.

"To a reader who would nourish his taste on the boundless harvests of the poetry of mankind, this sewage outfall of today offers as little in creative as in moral value. Lurid and irregular streaks of imagination, extravagance of plot and incident, petty and mean subjects of study, forced and unnatural situations, morbid pathology of crime, dull copying of the dullest commonplace, melodramatic hurly-burly, form the certain evidence of an art that is exhausted, produced by men and women to whom it is become a mere trade, in an age wherein change and excitement have corrupted the power of pure enjoyment.

"They are not books, these things,

To imbibe this compound is not to read."

Yet with all that has been said, and with all that may be said to the end of the chapter, against bad reading, which includes reading without thought as well as reading bad books with thinking, there is a worse state and habit of mind towards books, and that is the neglect of all books.

This custom is widespread. It is especially noticeable among the busy and so-called practical men of affairs. Their common excuse for not reading is that they haven't time. The excuse is plausible, but not valid. It is born of that nervous commercial spirit and mood of our age which regards business as the principal, if not the sole occupation of men who are capable of doing things..

Our age believes that man shall live by bread alone, and by whatsoever shall produce more bread.

Being too busy to read may be the excuse of a mental over-strain or excessive weariness, but it is not intelligent or praiseworthy for a mind that is normal.

Mr. Roosevelt is quite as busy a man as most men are, and yet he finds time to enjoy his literary favorites, and even to make new acquaintances in the book world. So Mr. Balfour, *et al.*

The secret of all acquisitive reading is to follow it consistently. This may be by piecemeal, and yet be consistent, and line upon line—"poco a poco."

If we shall wait until we have plenty of time, it will never come. Other occupations will intervene, causing habits and moods of mind which will make us unfit for our reading, however much of leisure we may have.

Perhaps it only needs that the attention of this University Club shall be called to this subject in order to start serious reflection and earnest action hereon.

#### **RULES FOR RESIDENT PHYSICIANS.**

Resident physicians shall be selected by competitive examination by the Committee on Residents subject to the ap-

proval of the staff, and elected by the Board of Managers. Applicants shall sign an agreement binding themselves, if elected, to accept the appointments to serve the whole term prescribed by the hospital, and to observe the rules and regulations governing their conduct while in the institution. All residents shall not charge or receive fees for at-be graduates of regular medical schools in good standing.

2. Residents shall reside in the hospital and shall receive board, lodging and laundry. They shall otherwise serve without compensation, they shall do no outside medical or surgical work, and shall not charge or receive fees for attending patients during their terms of service in the hospital.

3. Each resident shall be responsible for all patients under his care in the absence of the chief and assistant (if any).

4. He shall follow strictly the instructions of his chief, and equally those of the assistant.

5. In case of emergency or in case of doubt as to the course to be pursued, he shall communicate at once by telephone with the chief or assistant, but shall not, except for good and sufficient reasons, interfere with the orders of the chief or assistant.

6. No resident shall absent himself from the hospital without first arranging with a fellow-resident for the proper care of his patients, acquainting him thoroughly with the condition and needs of those who may require attention. He shall also notify the office of his intended absence and of its probable duration, and shall register in the book provided for the purpose the dates and hours of his departure and return.

Leave of absence for a longer period than twelve hours may be granted only by the superintendent, with the approval of the Committee on Residents, and after satisfactory provision has been made for the proper performance of the duties of the absentee.

7. One resident shall always be in

the hospital, except at the time of an emergency ambulance call, when the other resident is out.

8. Each resident shall visit all patients under his care twice daily (morning and evening). He shall record all his prescriptions and directions for their administration and all his orders for the treatment of patients in books provided for the purpose in each ward.

9. He shall keep a list of all cases under his care and shall furnish a daily list to each of two chiefs and assistants when so requested.

10. He shall keep accurate histories of all patients treated in his service to the satisfaction of his chief, and the management.

11. He shall not prescribe potent drugs in the absence of the chief or assistant except by direction or in emergency.

12. He shall attend his chiefs on their rounds, giving preference in case of conflict, according to the rules mutually agreed upon by his chiefs.

13. He shall have prompt access to such dressings and instruments as may be necessary in the course of his prescribed work, and in emergency, but he shall not perform any surgical operation except as shall be designated by the attending surgeon, and neither shall he employ any obstetrical instruments with a view to delivery, except upon the specific instructions of the attending obstetrician.

14. He shall avoid visits to the women's private rooms, except when attended by a nurse.

15. He shall not make vaginal examinations without the knowledge, and upon the advice of the chief of the department concerned, except in an emergency case, when it will be necessary to report the same to the superintendent, and afterwards to his chief. All such examinations shall be made in the presence of at least one nurse.

16. Patients shall not be moved from one ward to another, or from one bed

to another in the same ward without a written order from the superintendent or her clerk. Neither shall private room patients be moved from one room to another without the consent of the physician or surgeon in charge of the case, and then only upon written order of the superintendent or clerk.

17. Residents shall not dismiss patients without the specific directions of their chief.

18. The medical resident shall admit all patients to the hospital by filling out the blanks provided for the purpose, and shall at once turn the same into the office for the approval of the Superintendent or clerk. He shall examine each patient sufficiently to determine whether or not it is a proper case for admission, and if so, to further determine to what department the case shall be assigned.

19. Each resident shall be responsible for the making of such analyses as may be ordered by the attending physician or required in routine hospital work. The urine of each patient shall be examined within twenty-four hours following admission. When necessary the patient shall be catheterized for this purpose.

20. Immediately following the discharge, death, or transfer of a patient, the resident in charge shall collect all the case history sheets, fill in the necessary data, and deliver them either in person or by messenger to the superintendent.

21. Permission to perform an autopsy shall be obtained, when possible, from the patient's relatives, and if such permission is obtained the pathologist and attending physician or surgeon shall be promptly notified.

22. All patients dying under suspicious circumstances, or as the result of an accident, shall be immediately reported to the Coroner by telephone, and the Coroner's blank filled out and left at the office. Upon the death of any patient (except in Coroner's cases) a death



certificate shall be promptly filled and left at the office.

23. Residents shall not publish reports of cases or exhibit pathological specimens at the meetings of societies without the consent of the physicians or surgeons having charge of the case, and neither shall they give information to newspaper reporters or others concerning anything which occurs in the hospital or to patients without consultation with the management.

24. Residents are expected to have morning rounds and daily dressings completed by 11 a. m. Evening rounds shall be made before 8 p.m. except when unavoidable.

25. Residents shall give such instructions to orderlies and male nurses as may be necessary for the proper performance of their duties with patients.

26. Residents shall give such instructions to nurses as may be necessary to carry out orders and secure efficient services, but shall not reprove or discipline them for dereliction of duty. Any complaints concerning nurses shall be promptly reported to the Superintendent of Nurses.

27. Relations between resident physicians and pupil nurses of the training school shall be of a professional character only.

28. Residents shall not prescribe for nurses or visit them when ill except when requested to do so by the Superintendent. In all such cases the resident shall be accompanied by a nurse.

29. Each resident on the completion of his term of service shall be given a certificate stating the time spent in the hospital, and signed by the President of Board of Managers, and the members of the hospital staff.

The management and staff reserve the right, however, to withhold the certificate from any resident for good and sufficient reasons.

30. Residents shall comply with the requests of the Superintendent. Misunderstandings and grievances between the

resident on the one side and the staff and management on the other shall be referred for adjustment to the Committee on Residents. This committee is responsible to both the staff and management for the conduct of residents, and when necessary will refer to them such serious troubles as call for discipline or dismissal. The Board of Managers, on recommendation of the medical staff, may at any time dismiss a resident for inefficiency, neglect of duty, violation of rules or improper conduct.

31. Smoking in the hospital, except in residents' private rooms, will not be permitted. Any resident found in any degree of intoxication shall be suspended by the Superintendent, pending the investigation of the Committee on Residents.—*The National Hospital Record*.

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#### CALIFORNIA STATE BOARD OF MEDICAL EXAMINERS—RULES ADOPTED IN AUGUST, 1906.

RULE I. Regular meetings of the Board of Medical Examiners of the State of California will be held on the first Tuesday of each April, August and December. Examinations will be held on the third Tuesday of each April, August and December, unless otherwise ordered by the Board. Only necessary routine business may be transacted at any meeting held on a first Tuesday of any month.

RULE II. The deliberations of this Board shall be governed by Robert's Rules of Order, so far as they do not conflict with the State law under which this Board is organized, nor with other rules adopted by this Board.

RULE III. Any motion to add to, rescind, alter or suspend these rules or any part thereof, shall be submitted to the Committee on Rules without debate. Upon the favorable report of the committee, said motion shall be put before the Board for action. but, if

adopted, shall not become operative until the next regular meeting.

RULE IV. There shall be three standing committees, to-wit: One, of three members, upon rules; one, of three members, upon credentials of applicants; one, of two members, upon auditing of accounts.

RULE V. In determining the standard of grammar and high schools, academies, colleges (other than medical) and universities, the opinion of the Recorder or of the Credential Committee of the University of California shall be taken as a guide by this Board.

RULE VI. As applications are received, the Secretary shall immediately place at the disposal of the Committee on Credentials all documents relating to each and every new applicant. Said committee shall, upon the first day of each regular meeting, report to the Secretary the result of their investigation. The Secretary shall thereupon, within twenty-four hours, mail to the address of each applicant a permit to take the examination; or, in lieu of such a permit, a statement showing in what respect the credentials and documents of the applicant are incomplete or defective, together with notice that said applicant may appeal, in person or by attorney, to the full Board at its next meeting—specifying date and hour.

RULE VII. An adjourned meeting of the Board shall be held in San Francisco at 9 a. m. on the day upon which each examination shall begin. At this meeting the Committee on Credentials shall present to the Board, and to each individual member thereof, a formal, complete and typewritten report. This report shall include a list of the names of applicants to whom permits to take the examination shall have been issued; it shall specify, as regards each applicant individually, the reason why his or her credentials or documents, or any part thereof, shall have been deemed incomplete or defective by said committee. Thereupon any applicant to

whom a permit shall have been refused, or not issued, may appear before the Board, in person or by counsel, and may present an amendment to his or her credentials or documents, or may appeal to the Board from the decision of the committee. In case the amendment is accepted or the appeal sustained by the Board, the Secretary shall at once issue a permit to said applicant.

RULE VIII. Immediately before an examination begins, a numbered envelope will be handed to each applicant. Into this envelope the applicant shall insert his permit, after having signed his name and address to said permit, and shall then seal the envelope. Said envelope shall then be returned to the custody of the Secretary and shall not be opened until all the markings connected with that examination shall have been completed, and then only in the presence of the Board. The number of the envelope shall become the number of the applicant whose name shall have been inserted therein. Each applicant shall remember his or her own number and shall inscribe it, in plain figures, upon the exterior of each set of examination papers. No other mark shall be placed upon any paper whereby the identity of the applicant may be discovered.

RULE IX. Each member of the Board to whom a subject to examine upon shall have been allotted shall prepare upon any paper whereby the identity of printed, a list of questions, at least ten of which must be answered by each applicant.

RULE X. All questions must be answered in English, in writing made with ink.

RULE XI. All questions must be practical in character and, upon review of any papers by the Board, the practical character of the questions shall be considered in grading and marking papers.

RULE XII. Each question shall be

graded and marked separately upon a scale of 1 to 10, in plain figures in ink, upon the margin of the examination paper. The total attained shall then be computed and marked upon the exterior of said paper.

**RULE XIII.** Each of the following, when made a part of any examination, shall constitute one question: (a) Identification of microscopic preparations; (b) identification of gross pathologic preparations; (c) clinical examination of patients; (d) any other practical work. In all such cases questions must be answered in writing as a part of the examination paper, in order that the identity of the applicant may not be revealed to the examiner.

**RULE XIV.** No oral, clinical or other form of examination shall be conducted in a manner that will permit the applicant to reveal the identity of his or her number to an examiner, or to any other person.

**RULE XV.** During an examination no applicant shall consult, or open for inspection, any book, notes or other aids to memory; hold any communication with any other applicant; smoke tobacco; leave the room prior to the completion of his paper, unless accompanied by a member of the Board or by an inspector appointed by the Board; create any unnecessary noise or disturbance; introduce into the room any visitor or friend. Violation of this rule will be punished by exclusion from the examination.

**RULE XVI.** Two hours shall be allowed for the completion of papers upon each subject.

**RULE XVII.** Upon its completion, each examination paper shall be deposited by the writer thereof in a ballot box to be provided for the purpose by the Secretary. No examiner nor other person shall be permitted to handle or to inspect any such paper until after its removal from said box. No paper shall be removed from said box until after all papers relating to the same subject

shall have been deposited therein, and only then by a member of the Board. Each applicant is absolutely forbidden to reveal the identity of his or her number to any examiner, or to any other person, under penalty, if discovered, of summary rejection.

**RULE XVIII.** Each examiner shall be responsible for the removal from the ballot box of all papers relating to the subject allotted to him, for the correct marking of the same, and for the delivery of the same to the Secretary before 10 o'clock a.m. of the day next succeeding the last examination.

**RULE XIX.** *Sec. 1.* On the day following the last day of examination the Secretary shall record upon a chart prepared for the purpose, the number of each envelope, and beneath that number the markings attained in each subject by the examination papers correspondingly numbered.

*Sec. 2.* The numbers showing an average mark of not less than 75 per cent., and also a mark of not less than 60 per cent. on any one subject, shall be deemed to have passed the examination.

*Sec. 3.* When it appears that any number has attained an average of at least 75 per cent., and yet has failed to attain at least 60 per cent. on any one or more subjects, then the Board shall review papers so numbered, so far as they relate to defective subjects, and shall, by vote, re-mark each answer thereof, and the result arrived at by the Board shall be inserted in the chart, instead of the original marking.

*Sec. 4.* All numbers which shall finally appear to have attained an average of less than 75 per cent., or which shall have attained less than 60 per cent. upon any one or more subjects, shall be deemed to have failed.

*Sec. 5.* The numbered envelopes shall then be opened and the name on the permit contained therein shall be attached to the numbers on the chart corresponding to the numbers on the



envelopes, thus determining the identity of each applicant.

*Sec. 6.* After the numbered envelopes shall have been opened, no change whatever shall be made in the markings or their result, except as hereinafter specified.

**RULE XX.** Within three days after the success or failure of applicants shall have been determined, the Secretary shall send, per express or otherwise, to the address of each successful applicant a license to practice medicine and surgery in the State of California, properly signed and sealed. And he shall send, per mail, to the address of each unsuccessful applicant a statement showing his or her markings in each subject.

**RULE XXI.** Applicants for re-examination must, not later than the first Tuesday of any April, August or December, following the legal interval after their last examination, make application to the Secretary for a permit, in the form prescribed for the first examination and accompanied by the same fee, except that no credentials need accompany the application. The Secretary shall thereupon issue to such applicants permits to take the next ensuing examination.

**RULE XXII.** On the last day of each examination the Secretary shall return to each applicant present at the examination his or her diploma and other documents, taking therefor a receipt from each specifying all documents delivered.

**RULE XXIII.** Any clerical error in computing the results of the markings may be corrected at any time by the Secretary. But such correction must be reported to the Board at its next session.

**RULE XXIV.** At the meetings in each April, August and December the Secretary and Treasurer shall present a complete report of receipts and expenditures, which shall be referred to the Auditing Committee.

## AUGUST, 1906 EXAMINATION QUESTIONS OF THE CALIFORNIA STATE BOARD

EXAMINATION HELD AT  
LOS ANGELES AND SAN FRANCISCO,  
August 21-23, 1906.

### ANATOMY.

Answer any ten questions. **NO MORE.**

**DO NOT FAIL** to number the questions answered.

1. Describe the ankle joint.
2. Describe the clavicle and give its articulations.
3. Describe and give the use of the pleura.
4. Describe the popliteal space.
5. Describe the spermatic cord.
6. Describe and give use of the mesentery.
7. Describe and give use of the great omentum (gastro-colic).
8. What veins carry arterial blood?
9. Define: Pulmonary veins, systemic veins, portal vein, hepatic veins.
10. What structures are enclosed within the broad ligaments of the uterus?
11. Locate and describe Wharton's duct.
12. Name the principal salivary glands.
13. Name the cranial nerves.
14. Give origin and insertion of pectoralis major muscle.
15. What group of muscles have a common origin from the external and internal condyles of the humerus?

\* \* \*

### PHYSIOLOGY.

1. Discuss briefly the subject of animal heat.
2. Classify the food substances necessary to the maintenance of health, and give examples under each class.
3. Describe and give the function of the white blood corpuscles.
4. Trace the digestion of a glass of milk.
5. (a) Name and locate the papillae of the tongue. (b) What nerves are concerned in taste?
6. (a) Describe the phenomena of normal menstruation. (b) What is the probable physiological significance of menstruation?
7. Distinguish between cerebral and spinal paralysis in (a) reflexes, (b) nutrition of muscles, (c) electrical reaction of muscles.
8. Name the nerve supply to each muscle of the eye.
9. Where are the following centres: visual, auditory, respiratory, parturition, speech.
10. Define: (a) Eupnea, (b) chemotaxis, (c) ptomain, (d) myopia, (e) glycogen, (f) peristalsis, (g) cloaca, (h) hemolysis, (i) lechia, (j) pyrazine.

\* \* \*

### CHEMISTRY.

1. Define and illustrate (a) mixture; (b) compound; (c) molecule; (d) salt; (e) endomosis.
2. What temperature Fahrenheit is equivalent to a temperature of 28 deg. Centigrade? What temperature is equivalent to a temperature of 100 deg. Fahrenheit?
3. What is nitroglycerine? How is nitroglycerine prepared?
4. Name and describe four elements commonly present in organic bodies.
5. What are the principal chemical constituents of the blood?
6. Describe a test for bilberry acids.
7. What chemical tests may be applied to

- determine whether a given deposit in urine is a urate or a phosphate?  
 8. Define toxicology, antagonist, corrosive, narcotic, ptomain.  
 9. What kind of evidence, besides that called the symptoms, may serve to indicate the poison taken in a case of poisoning? Which of these is considered the most reliable?  
 10. Name the best chemical antidote for: corrosive sublimate, lead water, oxalic acid, Paris green, tincture of iodine.

\* \* \*

## PATHOLOGY.

1. Enumerate in the order of frequency the tumors involving the brain.
  2. Describe and give the sources of fat embolism.
  3. Enumerate the epithelial tumors.
  4. Define: (1), metaplasia; (2), argyria; (3), cysticercus cellulosae.
  5. Describe in detail the lesions found in tuberculosis of the intestine.
  6. Give normal structure of lymphatic gland.
  7. Describe the lesions in carcinoma of the cervix, and state the diagnostic value of microscopical examination of scrapings in such cases.
  8. What tests would be indicated in pyuria of renal origin?
  9. Examination of gross pathological specimens (Diagnosis of ONE specimen).
  10. Examination of microscopical specimens (ONE slide).
- Don't forget to give the number of the specimen and slide examined.

\* \* \*

## BACTERIOLOGY.

1. Enumerate the micro-organisms most frequently found in (1), acute peritonitis; (2), osteomyelitis; (3), pulmonary gangrene; (3), conjunctivitis.
2. Describe and discuss the value of bacteriological examination of milk.
3. Discuss the role of the colon bacillus in human pathology.
4. State the value of the tuberculin reaction in man and cattle.
5. What laboratory methods may be of service in the diagnosis of syphilis?
6. Discuss the respective value of the various laboratory methods in the early diagnosis of typhoid fever.
7. Name three ciliated pathogenic bacteria.
8. How would you make a bacteriological examination of water?
9. Describe the effect of desiccation of bacteria.
10. Where is the smegma bacillus found, and how would you differentiate it from other bacteria?

\* \* \*

## OBSTETRICS.

- J. Park Dougall, M. D., Los Angeles.
1. Define the terms, position, presentation, version, rotation.
  2. Describe in detail how you would conduct a normal labor.
  3. Discuss the antiseptic measures that should be employed during labor and the puerperal period.
  4. Give the pathology, symptoms and treatment of puerperal sepsis.
  5. Name the causes of sterility.
  6. Discuss the use of anaesthetics in labor. When and what would you use?
  7. Enumerate the varieties of placenta previa, give diagnosis and treatment.
  8. Give the pathology, prognosis and treatment of puerperal eclampsia.
  9. What is menstruation?
  10. Describe Crede's method for delivery of the placenta.

\* \* \*

## SURGERY.

1. Give dressing and position of forearm in fracture of olecranon process.

2. Give management of case of multiple fracture of inferior maxilla.
3. Describe manipulation for reduction of backward dislocation of femur (on dorsum ilii).
4. Describe two methods of surgical procedure in pleural empyema.
5. Describe a recognized method of prostatectomy.
6. What are the indications for resection of head of humerus?
7. Give treatment of prolapsus ani.
8. Diagnosis of aneurism of aorta.
9. Diagnosis of malignant stenosis of pylorus.
10. Mention various cases and clinical features of spinal curvature.

J. B. MITCHELL, M.D.

\* \* \*

## MATERIA MEDICA.

[Regular.]

1. Define Volt, Ampere, Ohm and give Ohm's law.
2. Name the source of the following alkaloids: codeine, atropine, narcotine, brucine, cocaine, physostigmine, pilocarpine, caffeine, theobromine, colchicine.
3. What symptoms indicate acetanilid poisoning?
4. State the adult dose of Tr. aconite, chloral hydrate, cocaine hydrochlorate, croton oil, Tr. digitalis, Tr. Gelsemium, Tr. opium, mercuric chloride, methylene blue, zinc sulphate.
5. Explain the distinction between (a) the physiological action and (b) the therapeutic use of drugs.
6. What symptoms indicate excessive doses of salol?
7. How would you treat poisoning from (a) common lye? (b) wood alcohol? (c) illuminating gas? (d) acids generally? (e) an unknown cause?
8. What are the symptoms of iodism?
9. How would you disinfect a room in a private dwelling after its occupancy by a patient suffering from an infectious disease?
10. State the therapeutic uses of picric acid.

JNO. C. KING.

\* \* \*

## MATERIA MEDICA.

[Homeopathic.]

1. Give the symptoms indicating arsenicum alb. and veratrum alb. in acute diarrhoea.
2. In acute colds or coryza, what symptoms would decide you to give aconite, gelsemium, arsenicum or allium cepa?
3. Name three remedies for amenorrhoea and give characteristic symptoms.
4. Name three remedies prominent in the treatment of typhoid fever and give the indicating symptoms.
5. Compare bryonia and rhus. tox. as indicated in rheumatism.
6. Name three remedies, giving four characteristic symptoms of each, for headache.
7. Give the brain and mental symptoms produced by a proving of belladonna.
8. Give indications for the use, in menorrhagia, of bovista, sabina and trillium.
9. Name three emetics. Give dose and instructions for the use of each.
10. How would you recognize poisoning by opium and by strychnia? Give proper treatment for each.

\* \* \*

## MATERIA MEDICA.

[Eclectic.]

- J. Park Dougall, M.D., Los Angeles.
1. Define anthelmintics, carminatives, demulcents, emollients, errhines, sialagogues.
  2. Give the source, indication and dosage, apis mellifica; give synonym and dose of avena sativa.
  3. Define infusion, decoction, tincture, cerate.

4. State how you would proceed to make an emulsion.
5. Give the indication, digitalis, strychnine, digitalis, with special reference to their action on the heart.
6. Name a general antidote for poisoning by alkaloids.
7. State the medicinal properties, aconite, gelsemium, castor.
8. State the incompatibles of emulsion.
9. How would you exhibit streptococcus and why?
10. Name four antipyretics, four hypnotics, four analgesics.

\* \* \*

#### MEDICINE—REGULAR

1. Describe the eruption of variola.
2. How does the echinococcus reach the liver?
3. Give diagnosis of pancreatic cyst.
4. Give blood findings in chlorosis.
5. Give symptoms of exophthalmic goiter.
6. Give diagnosis of aneurism of transverse portion arch of aorta.
7. Give symptoms of tuberculous peritonitis.
8. Give causes of hepatogenic jaundice.
9. Give symptoms of cocaine poisoning.
10. Give concisely the salient points in the diagnosis of typhoid fever.

\* \* \*

#### MEDICINE—HOMEOPATHIC

1. Give the urinary findings in diabetes mellitus, in interstitial nephritis.
2. How would you recognize internal hemorrhage?

3. Give diagnosis, most common sequelae, and treatment of scarlatina.
4. Give diagnosis, most common sequelae, and treatment of rheumatic fever.
5. How would you proceed, as to diagnosis and treatment, if called to a patient found in an unconscious state?
6. How would you differentiate pleur from carcinoma of the stomach? What treatment would you advise in both conditions?
7. Diagnose and outline treatment for acute enteritis.
8. Diagnose and outline treatment for chronic editis.
9. Give diagnosis and treatment for diphtheria.
10. What is dropsy? Mention the various causes.

#### MEDICINE—ECLECTIC

1. What is the significance of fever?
2. Mention 4 characteristic varieties of pulse, with remedy for each.
3. Mention 4 characteristic appearances of tongue, with remedy for each.
4. Mention 4 remedies usually indicated in typhoid fever.
5. Give treatment of erysipelas.
6. What causes produce normal systolic sound of heart? What changes in sound in mitral incompetence?
7. Give treatment of typical case of lobar pneumonia.
8. Why are arterial sedatives and diaphoretics of value in chronic nephritis?
9. Give treatment of measles.
10. Differential diagnosis of gall stones.

J. B. MITCHELL, M.D.

## SAN FRANCISCO DIRECTORY.

Abbott, P. E., Cooper Medical College.  
 Abbott, C. T., 2907 Devisadero St.  
 Abraham, Henry, 1426 Fulton St.  
 Abrams, A., 2507 Pacific Ave.  
 Adams, Mary, 1456 Ellis St.  
 Adam, Gen., 2109 California St. & 2188 Green  
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 Oakland.  
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 2118 Sacramento St.  
 Alexander, Edg. W., 1206a 9th Ave., (Sunset.)  
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 Allen, L. W., St. Luke's Hospital.  
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 Barbat, Henry J., 1360 Post St. (Clara Barton  
 Hospital) and 1418 Sutter St.  
 Barbat, Wm. F., 2305 Howard St.  
 Barger, D. E., 2918 Broderick St.  
 Barkan, A., Lane Hospital and Cooper Medi-  
 cal College.  
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 Besson, E. A., 812 Turk St.  
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 Billingsley, U. C., 504 Haight St.  
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 Black, J. A., 2373 Jackson St.  
 Blaisdell, F. E., 1632 Post St.  
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 Bloch, Herbert, 2156 Sutter St.  
 Bluhm, Geo., 1906 Bush St.  
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 Blumer, Geo., Med. Dept. Yale University.  
 Bodkin, T. B., 367 Haight St.  
 Bohm, E. A., 1805 Broadway (temporarily)  
 Boldemann, Lillie, 2624 Sutter St.  
 Bonne, E., 405 Baker St.  
 Born, J. A., 2293 Howard St.  
 Boskowitz, Geo. H., 1887 Sutter St.  
 Bothe, A., 562 Clayton St.  
 Boughton, H. J., 792 McAlister St.  
 Boyd, Sam, C., 236 Ashbury St.  
 Bowes, M. F., 2615 Pacific Ave.  
 Bowie, H. C., 1046 McAllister St.  
 Boxton, Chas., 60 Pierce St.  
 Brackett, Geo. F., 148 Noe St.  
 Brady, Geo. T., 687 Hayes St.  
 Brady, J. G., 1001 Guerrero St., 1-3.  
 Brayton, H. W., 18th and Castro Sts.  
 Brinkerhoff, Emilie, cor. Laguna & Market Sts., (camp)  
 Breyfogle, E. S., 2509 Pacific Ave.  
 Broderick, R. G., 3808 Clay St.  
 Brown, Adelaide, 3146 Clay St.  
 Brown, Ella P., 1116 Brush St., Oakland  
 Brown, Ph. King, 2527 Fillmore.  
 Brune, A. E., 405 Baker St.  
 Bryant, Edg. R., 1944 Fillmore St.  
 Buckley, Emma, Fort Mason.  
 Bucknall, G. J., 1121 Laguna St.  
 Buell, W. E., 1116 18th St.  
 Bullock, R. R., 1982 Folsom St.  
 Burgess, O. O., 156 12th St., Richmond Dist.  
 Burns, R., 1680 Ellis St.  
 Burns, M. W., 1398 49th Ave.  
 Burnham, W. P., 83 Devisadero St.  
 Burke, Jos. G., 2150 Sutter St.  
 Burton, B. F., 647 9th Ave.  
 Button, Julia F., 3005 California St.  
 Buzard, A. E., 140 26th Ave.  
 Byrne, W. M., 894 Eddy St.

Cadwallader, R., 1429 Haight St.  
 Calhoun, J. W., (Fort Mason) 1778 Eddy St.  
 Campbell, Mary P., 2811 Harrison St.  
 Canney, F. G., cor. Sutter & Buchanan Sts.  
 Card, C. W., 502 Devisadero St.  
 Carlson, Ch. H., 1618 Hayes St.  
 Carney, F. G., 1548 Page St.  
 Carpenter, F. B., 1824 Pacific Ave.  
 Carpenter, Louis, 1498 Fulton St.  
 Castelhun, P., 1078 Valencia St.  
 Cerf, A. E., 2871 Clay St.  
 Chadwick, F. C., 218 18th Ave.  
 Chalmers, Wm. P., 1904 Page St.  
 Cheney, Wm. F., Cooper Medical College & Spruce St., 33.  
 Cherry, E. M., 2507 Sacramento St.  
 Chipman, E. D., Ross, Marin county.  
 Chisholm, Mary, 1643 Page St.  
 Clark, Ch., 1408 McAllister St.  
 Clark, J. R., 1808 Gough St.  
 Clark, Wm. D., 2534 California St.  
 Clark, W. R. P., 982 Hayes St.  
 Cleary, St., 267 4th Ave.  
 Coffey, W. B., 1503 McAllister St.  
 Cohen, Albert, 2915 California St.  
 Cohn, David, 1404 Sutter St.  
 Cohn, Robert, 1404 Sutter St.  
 Coleman, Emmette, 1609 Gough St.  
 Collins, A. W., 3303 Sacramento St.  
 Collischonn, Ph., 1924 Pine St.

Colton, A. C., 1059 Oak St.  
 Condon, C. E., 1843 Oak St.  
 Conlan, F. J. S., 2414a Sacramento St.  
 Cronan, P. J., 635 Devisadero St.  
 Cool, W. P., 339 Frederick St.  
 Cooper, Ch. M., 2226 Washington St., or German Hospital  
 Cornwall, F., 607 Van Ness Ave.  
 Cosgrave, Millicent, Cooper College, & 2619 Octavia  
 Costigan, Geo. D., Cooper Medical College.  
 Couper, E. W., 3301 Mission St.  
 Cox, L. C., 1497 O'Farrell St.  
 Crackbon, Lucy A., 2534 Mission St.  
 Crawford, J. G., 2436 Market St.  
 Crawford, W. F., 112 Scott St.  
 Criswell, R. B., 2309 Washington St.  
 Cross, Ch. V., 2804 California St.  
 Crothers, Wm. H., 145 Jordan Ave.  
 Crowley, Th. J., cor. Fillmore & Hayes Sts.  
 Cuhn, Geo. C., 97 Central Ave.  
 Culver, G. O., 97 Central Ave.  
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 Cunningham, S. J., 135 6th Ave.  
 Currier, C. B., 2084 O'Farrell St.  
 Cafferata, A. J., 1990 Sutter St.  
 Calender, M. N., 1255 19th Ave.  
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 Cummings, C. H., 503 Octavia St.

Davidson, Jos. R., 2119 Buchanan St.  
 Davis, Geo. E., 1208 Geary St.  
 Davis, W. L., 1254 8th St., Oakland.  
 Deal, Louise B., 1120 Valencia St.  
 Deane, Louis C., Mt. Zion Hospital.  
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 De la Hauteire, res. 1671 Golden Gate Ave.  
 Delmont, Francis, 831 Oak St.  
 De Marcennay, A., Mission High School.  
 D'Evelyn, Fred W., Emergency Camp Hospital, Alameda.  
 Donnelly, E. F., 1427 Webster St.  
 Dillon, John F., 2524 Market St.  
 Dodel, X., 1506 Ellis St.  
 Dodge, Washington, Clay & Laguna Sts.  
 Dolman, P., 2510 Bush St.  
 Dorr, L. L., 2023 Fillmore St.  
 Dorr, W. R., 2989 Howard St.  
 Dow, B. N., 806 Eddy St.  
 Downes, C. S., 930 Hayes St.  
 Downing, A. P., 872 Oak St.  
 Dozier, Ch. A., 827 Duboce Ave. & 300 Page  
 Draper, A. L., 2353 Pacific Ave.  
 Dray, F. R., 2353 Pacific Ave.  
 Drussell, B., 1109 Franklin St.  
 Drosel, Gustav, German Hospital.  
 Dransfield, C. C., 4160 20th St.  
 Duncan, Fr. E., 3276 California St.  
 Dunn, R. H., 779 14th St.  
 Dwight, Wilder, 2661 Clay St.

Eastland, Orin, 1274 12th Ave.  
 Easton, D. E. F., 900 Haight St.  
 Easton, S. F., Wagner, 3001 Devisadero.  
 Eaton, F. B., 2504 Clay St.  
 Eaton, G. L., 1134 Masonic Ave.  
 Ebright, Geo. E., 2500 Fillmore St.  
 Edmonds, F. W., 2203 Atherton Place, Berkeley.  
 Edwards, Carrie, 745 Ashbury St.  
 Edwards, C. H., 727 Ashbury St.  
 Edwards, Wm., 1120 Masonic Ave.  
 Ehrlich, B. B., 1578 Fulton St.  
 Eichler, Alfred, cor. Castro, Market & 17th  
 Edenmuller, Wm. C., 708 2d Ave., Richmond  
 Eklund, Oscar E., 1914 Pacific Ave. & 1673 Sutter St.

Ellinwood, C. H., 2739 Pacific Ave.  
 Ellis, L. R., res. 1928 Post St., office 1800 Turk  
 Elmer, J. H. Geary & Van Ness Ave.  
 Emmal, F. S., 2689 Howard St.  
 Etcheverry, M. H., 2341 Post St.  
 Evans, Geo. H., 2526 Washington St.

Fanning, H. D., 1480 Church St.  
 Farmer, Jessie C., 311½ Church St.  
 Farnum, Ch. E., 513 Devisadero St.  
 Fehleisen, F., 902 Devisadero St.  
 Fenner, I. R., 289 1st Ave.  
 Field, Edna R., 1230 Geary St.  
 Fife, J., 2802 California St.  
 Finnie, W. F., 2326 California St.  
 Fischer, Frank, 3356 Sacramento St.  
 Fisher, A. L., 1718 Jackson St.  
 Fitzgibbon, G. J., 204 Haight St.  
 Fleming, B. F., Port Mason  
 Flynn, A. M., 2442 Clay St.  
 Foreman, F. J., 127 Athol Ave., Oakland.  
 Forster, W. M., 906 Eddy St.  
 Foss, H., 2329 Market St.  
 Fottrell, M. J., 1513 Devisadero St.  
 Frankenheimer, J., 1941 Webster St.  
 Franklin, W. Scott, 2470 Bush St.  
 Frederick, M. W., 2152 Sutter St.  
 Freeman, G. M., Berkeley Inn, Berkeley, Cal.  
 French, Ch. E., 1914 Pine St.  
 Friedlander, D., 2501 Washington St.  
 Frink, Geo. K., 2626 Valjejo St.  
 Frisbie, E. G., 2501 California St.  
 Fritag, F., 822 Turk St.  
 Frost, Jas., 2427 Mission St.  
 Fuller, Geo. W., cor. Clay and Fillmore Sts.  
 Fuson, A. U., 2501½ Mission St.

Gables, M. F., 307 Spruce St.  
 Gale, H. A., 889 Haight St.  
 Galbreath, A. J., 2724 Clement St.  
 Gallagher, J. J., 918 Broderick St.  
 Gallwey, John, 1025 Devisadero St.  
 Garceau, A., 2500 Fillmore St.  
 Gavigan, W. G., 1628 Post St.  
 Gedney, F. M., 1332 Broadway.  
 Gedge, D. McC., 2924 Steiner St.  
 Genss, Bruno, 2312 Clay St.  
 Gere, Geo. G., 1762 Waller St.  
 Graves, J. H., 987 Valencia St.  
 Giannini, A. A., 2745 Van Ness Ave.  
 Gibbons, Henry, Jr., Cooper Medical College  
 and 3979 Washington St.  
 Gibbons, Morten R., Cooper Medical College  
 and 3979 Washington St.  
 Gibbons, Henry W., Cooper Medical College  
 and 3979 Washington St.  
 Giberson, N., 1902 Union St.  
 Goodale, G. W., 1952 Devisadero St.  
 Goodfellow, Geo. E., 1794 Sutter St.  
 Goodman, Laura, 2089 15th St.  
 Graham, H. B., 1796 Post St.  
 Goss, Alice, 1792 Sutter St.  
 Graham, L., 18th and Missouri Sts.  
 Gray, F. P., 1808 Fillmore St. and Cooper  
 Medical College.

Grazer, F. A., 501 3d Ave.  
 Green, J., 2802 California St.  
 Greenlaw, M. A., 281 Frederick  
 Grimm, Ch. H., 421 Clement St.  
 Griswold, W. H., 894 Eddy St.  
 Gross, Geo., 1703 O'Farrell St.; res. 1348  
 O'Farrell St.  
 Gross, Louis, 2526 Clay St.  
 Grosse, A. B., 2160 Post St.  
 Gruggel, O. L., 2329 Pine St.  
 Grumm, C. H., 421 Clement St.

Haderle, John, 633 Hayes St.  
 Hall, A. P., 1973 Sutter St.  
 Hamilton, Jesse W., 542 Shrader.  
 Hamilton, J. K., 402 Hayes St.

Hanlon, J. S., St. Joseph's Hospital.  
 Hannah, J. B., 1869 Buchanan St.  
 Hanson, G. F., 555 Fillmore St.  
 Harding, —, 54 Webster St.  
 Harris, B. Y., 325 Presidio Ave.  
 Harris, C. S., 1252 Fell St.  
 Harris, Henry, 2470 Bush St.  
 Harris, Susan, 1854 Fell St.  
 Harrison, S. I., 3053 California St.  
 Hart, Henry H., 1421 Post St.  
 Hart, M. E., 897 Clayton St.  
 Hartley, R. E., 637 Hayes St.  
 Harvey, W. A., 1408 McAllister St.  
 Harvey, W. P., 2173 Pacific Ave.  
 Hashimoto, S., 1615 Gough.  
 Healy, J. H., 1816 Fillmore St.  
 Helms, Geo. L., 651 Fillmore St.  
 Henderson, J. J., 104 Laurel Place, San  
 Rafael.

Henslee, Wm., 1740 Sutter St.  
 Henry, Jos. W., 1311 Gough St.  
 Herrington, Edward, 1839 Fillmore St.  
 Herzog, G. K., 1869 Buchanan St.  
 Herzstein, Morris, 2113 Pacific Ave.  
 Hess, H. A., Martinez, Cal.  
 Hewett, Sophie B. Kobicke, 1309½ Waller  
 Hewlett, A. W., 2418 Washington St.  
 Hibbard, Carrie S., 626 Clayton St.  
 Hickey, John, 1445 Octavia St.  
 Higgins, R. M., 1534 McAllister St.  
 Hill, Harold P., 2375 Jackson St.  
 Hill, R. C., 930 Green St.  
 Himmelsbach, Wm., 1911 Pierce St.  
 Hirschfelder, J. O., 1392 Geary St.  
 Hirschowitz, L., 2702 California St.  
 Hodghead, D. A., 2285 Market St.  
 Hodghen, J. D., 2500 Fillmore St.  
 Hoffman, L. H., 3014 Washington St.  
 Holbrook, Geo. S., 1724 Broadway.  
 Holmgren, Ch. J., 1274 McAllister St.  
 Hopkins, E. K., Gough and Turk Sts.  
 Hopkins, H. H., 2373 Jackson St.  
 Hopkins, W. E., Gough and Turk Sts.  
 Hopper, W. C., 465 Castro St.  
 Horn, Henry, Henry Durant School, Turk  
 near Webster.

Houston, Alb., 2432 Sacramento St.  
 Moved to Washington & Fillmore.  
 Howard, J. L., 2439 Sacramento St.  
 Hubell, G. R., 1278 Fulton St.  
 Hubbell, G. R., 1278 Fulton St.  
 Hubbell Harriet, 1768 Shattuck Ave., Berke-  
 ley.

Huebener, G. A., 156 12th Ave.  
 Hughes, J. A., 1821 Eddy St.  
 Hund, O. H., 1690 Golden Gate Ave.  
 Hunkin, Sam., 2161 Sutter St.  
 Hunsaker, H. W., 2127 Fillmore St.  
 Huntington, Th. W., 2629 Pacific Ave.  
 Huntley, Arthur C., 1952 Devisadero St.  
 Hurd, Laura, 1833 Buchanan St.  
 Hurst, Alice, 270 7th Ave.  
 Hurst, Walter, 270 7th Ave.  
 Hyman, Sol., 1916 California St.

Iland, Minnie, 1141 Turk St.  
 Inman, Th. G., 984 Valencia St.

Jacobs, L. Chve., 2101 Pacific Ave. 1-3.  
 Jacobs, Louis, 1745 Pine St.  
 Jacobson, P. N., 1755 Post St.  
 Jakes, R. W., 629 Van Ness Ave.  
 Jamieson, W. R., 1902 Page St.  
 James, Thos. L., 1673 Sutter St.  
 Jeffrey, J. A., 1021 Hayes St.  
 Jellinek, E., 2226 Washington St. and Ger-  
 man Hospital.

Johansen, Ernest, 1809 Oak St.  
 Johns, E. Madeleine, 1088 McAllister St.  
 Johnson, A. W., 1060 Ellis St.  
 Johnson, F. F., 3004 24th St.



Johnson, W. S., 1836 Sutter St.  
 Johnson, H. J., 1902 Page St.  
 Jones, Ch. E., 1118 Guerrero St.  
 Jones, H. I., 228 E. 16th St., Oakland.  
 Jones, L. F., 2956 Mission St.  
 Jones, Ph. M., 1230 Telegraph Ave., Oakland.  
 Judell, Malvine, 1701 Buchanan St.  
 Juilly, Geo., cor. 21st and Howard Sts.

Kahl, Ch. W., 803 Douglass St.  
 Kahn, S. S., Mt. Zion Hospital.  
 Karr, E., 821 Webster St.  
 Kastendick, J., 547 Fillmore St.  
 Kaster, Eugene, 223 Scott St.  
 Kearny, P. A., 1917 Devisadero St.  
 Kearny, W. B., 1199 Valencia St.  
 Keck, Fred C., 500 Devisadero St.  
 Keeney, J. W., 2220 Clay St.  
 Keenan, A. S., cor. 24th and Harrison.  
 Kellog, W. H., 297 Devisadero St.  
 Kelly, E. E., 632 Fillmore St.  
 Kenyon, C. G., 2355 Pacific Ave.  
 Kergan, John A., 3368 Sacramento St.  
 Kerr, W. W., 2605 California St.  
 Key, J. W., 1005 Fillmore St.  
 Keys, Elizabeth, 2723 Sacramento St.  
 Kibbe, Minora, 1401 Arch St., Berkeley.  
 Kirk, Albert, 2127 Fillmore St.  
 Kirsh, Henry, 31 Tremont Ave.  
 Knorp, F. F., 3009 Sacramento St.  
 Kreutzmann, Henry, 2317 Webster St.  
 Kroetz, Mary M., 3396 16th St.  
 Koenigstein, G., 1813 Sutter St.  
 Koepke, F. H., 1266 9th Ave.  
 Korts, B. F., 914 Haight St.  
 Krotoszyner, M., 2672 Pine St.  
 Kuckein, Franz, 432 Webster St.  
 Kueich, O. S., cor. Grove and Laguna Sts.  
 Kugeler, H., 2210 Baker St.  
 Kuhlmann, Ch. G., 2182 Bush St.  
 Kuykendall, J. A., 35 South Broderick St.

Lacoste, H. L., 2431 Washington St.  
 Lagan, H., 72 Bartlett St.  
 Laist, Otto, 402 Haight St.  
 Lamb, E. T., 1707 O'Farrell St.  
 Lamb, L. A., 1707 O'Farrell St.  
 Lamb, W. M., 1680 Ellis St.  
 Lartigau, A. J., 1502½ Golden Gate Ave.  
 Lawler, W. M., 136 Carl St.  
 Leanord, A. T., 1513 Devisadero St.  
 Leithead, C. E., 1398 O'Farrell St.  
 Lee, Brooks B., 1611 Baker St.  
 LeFevre, J. P., 213 Ashbury St.  
 Leffler, John, 1808 Laguna St.  
 Leland, T. B. W., 1910 Vallejo St.  
 Leonhard, B. J., 339 Waller St.  
 Lensmann, Arthur P., 1308 Post St.  
 Lennon, M. B., 918 Eddy St.  
 Lermann, W., Lane Hospital, cor. Clay & Webster Sts.  
 Levinger, L. V., 1871 Sutter St.  
 Levison, Chas. G., 2420 Pacific.  
 Levy, J. W., 911 Eddy St.  
 Lewis, Emma A., 1408 McAllister St.  
 Lewitt, W. B., 2620 California St.  
 Lillard, J. W., Camp Lobos, tent No. 16, 1st St. Section "C."  
 Lillie, W. A., 817 Golden Gate Ave.  
 Likens, J. W., 1060 Devisadero St.  
 Linforth, Grace S., 418 Bartlett St.  
 Lissner, Louis, 3899 Washington St.  
 Loeffler, J., 1808 Laguna St.  
 Lofontaine, Emma, 1220 Geary St.  
 Logan, R. L., 2588 Pine St.  
 Long, S. F., 21 Buena Vista Ave.  
 Lonige, E. V., 1786 Union St.  
 Lord, Fr. F., 1191 Oak St.  
 Luchetti, F. V., 2105 Union St.  
 Lustig, D. D., 2502 Washington St.

Lux, F. W., 2420 Union St.  
 Lyle, A. G., 1150 Union St.  
 Lynch, Elizabeth, 668 Castro St.

MacDonald, J. M., 3026 Washington St.  
 Macdonald, Dr. Geo. Childs, 1117 Franklin St.  
 Macdonald, J. M., 1722 Oak St.  
 Mace, L. S., 3335 Washington St.  
 Maclean, D., 906 Eddy St.  
 Maas, P. H., 3989 17th St.  
 MacMonagle, B., 3522 Clay St.  
 Magnus, M. E., 687 Hayes St.  
 Magnus, Max, 681 Hayes St.  
 Maguire, C. S., 281 Page St.  
 Maguire, T. M., 281 Page St.  
 Maher, Th. D., 3543 23d St.  
 Maher, Th. D., 2620 Sacramento St.  
 Mahoney, Th., 2265 Union St.  
 Mahoney, Margaret, 1821 Broadway.  
 Malech, H. F., 758 Devisadero St.  
 Mangold, W. G., 665 Broderick St.  
 Mann, C. S., cor. Fell and Baker Sts.  
 Manning, G. E., 3675 Clay St.  
 Mansfeldt, Oscar, 603 Hayes St.  
 Manuel, Jennie, 1141 Turk St.  
 Mardis, B. A., 765 1st Ave.  
 Marshall, Jno. S., Presidio.  
 Marshall, Minora, 2442 Clay St.  
 Martin, Robert S., 1617 Page St., 2-4.  
 Martineau, E. D., 2149 Buchanan St.  
 Martin, W. A., 870 Fell St.  
 Martinez, F., 2109 Bush St.  
 Masoero, C., 214 Dolores St.  
 Mather, S. R., 754 Devisadero St.  
 Matsuda, M., 1819 Laguna St.  
 Mattner, E. H., 607 Van Ness Ave.  
 McCarthy, Ch. F., 2417 Washington St.  
 McCarthy, Wm. D., 2007 Devisadero St.  
 McChesney, J. G., 2210 Jackson St.  
 McConnell, A. B., 2373 Jackson St.  
 McConnell, E. G., 2373 Jackson St.  
 McCormick, R., 4348 18th St.  
 McDermott, Wm. P., 210 San Jose Ave.  
 McFadyen, 1784 Page St.  
 McFarlane, Arthur, 1217 9th Ave.  
 McGettigan, Ch. D., 630 Page St.  
 McGill, A. B., 1732 Steiner St.  
 McGinty, A. T., 1762 Page St.  
 McKee, A. B., Fillmore & Washington Sts.  
 McLaren, W. M., 1223 10th St.  
 McLaughlin, G. V., 727 Clayton St.  
 McLaughlin, Dr. A., Railroad and 11th Aves.  
 McLean, A. D., 1296 Turk St.  
 McLean, R. A., 1895 Sutter St.  
 McMurdo, J. R., 2026 Steiner St.  
 McMurray, Milton, 65 Partolla St.  
 McNeil, A., 611 Van Ness Ave.  
 McNutt, W. F., 2511 Pacific Ave.  
 Meierdicks, Wm. A., 318 Haight St.  
 Meininger, Leo, 3765 Clay St.  
 Mendel, Louis, 2148 Broderick St.  
 Mercer, Emma S., 2323 Washington St.  
 Merritt, Emma S., 2323 Washington St.  
 Mervy, E. C., 3025 Fillmore St.  
 Meyer, Henry, 2897 Jackson St.  
 Meyer, Albert S., 2651 Folsom St.  
 Millar, C. F., Receiving Hospital.  
 Miller, John A., 238 Tremont Ave.  
 Miller, Ch. N., 129 Haight St.  
 Miller, Thurlow, 1104 Devisadero St.  
 Milton, W. M., 82 Bartlett St.  
 Minaker, A. J., 224 San Jose Ave.  
 Minaker, R. M., 224 San Jose Ave.  
 Mish, S. C., 1075 Gough St.  
 Mitchell, J. B., 2420 Gough St.  
 Mix, P. A., 1457 Willard St.  
 Moffitt, Herb, 1818 Broadway.  
 Mohun, C. C., 1817 Eddy St.  
 Montgomery, D. W., 2419 California St.  
 Moody, R. O., 125 Belvedere.



Moore, A. C.  
 Moore, H. T., 2619 Bush St.  
 Mooshin, H. B., 723½ Turk St.  
 Morfrow, Thos., 1765 Pine St.  
 Morris, C. A., 872 Oak St.  
 Morris, A., 225 Lake St.  
 Morrissey, J. G., cor. Haight St. and Masonic Ave.  
 Morrow, Howard, cor. Gough & Turk Sts.  
 Morton, A. W., 775 Cole St.  
 Muller, F. C., 674 2nd Ave.  
 Munter, Lee, 2161 Pacific Ave.  
 Murphy, Jas. D., 1393 Golden Gate Ave.  
 Myers, Bernh., 1212 9th Ave.

Nagel, C. S. G., 1919 Vallejo St.  
 Nast, J. E., cor. Scott and Waller Sts.  
 Nelson, A. B., 906 Eddy St.  
 Nelson, Lois, 1770 Pacific Ave.  
 Nelte, Cullen, 2510 Washington St.  
 Newmark, Leo, 2230 Sacramento St.  
 Newman, A., 1707 Octavia St.  
 Newman, M., 1218 1st Ave.  
 Newton, J. C., 2092 O'Farrell St.  
 Nichols, R. J., 2519 Washington St.  
 Niemeyer, H. A., 502 Clement St.  
 Noble, J. Albert, 18th and Telegraph Ave., Oakland.  
 Noble, Maud, 611 Baker St.  
 Noble, Paul, 2298 Sutter St.  
 Novitzky, Jos., 1673 Sutter St.

O'Brien, A. P., 2066 Pine St.  
 O'Bannon, 1652 Haight St.  
 O'Connell, M. W., 814 Grove St.  
 O'Connell, R. E., 211 Devisadero St.  
 O'Connor, J. H., 2572 California St.  
 O'Donnell, G. W., 1212½ Turk St.  
 Ohrwall, H., 2510 Washington St.  
 Oliver, H. R., 1917 Fillmore St.  
 Oldham, F., 565 Waller St.  
 Olson, Dr. Claus, Massin, 2416 Webster St.  
 O'Neill, Melville, 612 Oak St.  
 O'Neill, A. A., Gen. Hosp., Presidio.  
 Ophuels, Wm., Cooper Med. College.  
 Orrella, F. R., 2414a Sacramento St.  
 Osborne, J., Fort Mason.  
 Osmer, Wm., Cooper Med. College and 629 Clayton St.  
 Osman, W. F., 1552 Haight St.

Pagué, F. C., 1916 Vallejo St.  
 Palmer, Geo. H., 2446 Jackson St.  
 Partridge, H., 2989 Howard St.  
 Pawlicki, C. F., 2709 Sacramento St.  
 Pawlicki, L., 2709 Sacramento St.  
 Payne, Clyde S., 3090 Clay St.  
 Payne, R. W., 2848 California St.  
 Pearce, C. H., 2004 Devisadero St.  
 Peck, R. Emery, 2901 Sacramento St.  
 Peck, Allen, 1805 Fillmore St.  
 Perkins, Ph. J., 309a Waller St.  
 Perrow, O., 2721 Mission St.  
 Perrault, E. L., 2332 Pine St.  
 Petty, J. Claude, 2588 Market St.  
 Perry, A. W., 1914 Sutter St.  
 Peters, Wm., 1402 18th St.  
 Petro, F. B., 211 South California St.  
 Peterson, A. C., Union Savings Bank bldg., Oakland.  
 Peole, J., 1765 Pine St.  
 Pfister, J. J., 2366 Green St.  
 Phelan, Henry DuR., 3276 24th St.  
 Philp, J. H., 2110 Steiner St.  
 Phillips, H. J., 906 Eddy St.  
 Phillips, F. H., 736a Clayton St.  
 Philip, Chas., 616 Baker St.  
 Pinkham, C. R., 2703 Bush St.  
 Planch, C., 1817 California St.  
 Plince, T. K., 884 Chestnut St.

Pope, B. M., Gen. Delivery, Sacramento.  
 Poaps, A. P., 1131 Laguna St.  
 Poehner, A. A., 1191 Pierce St.  
 Poheim, J., 1709 Steiner St.  
 Poole, Wm. E., 219½ Waller St.  
 Posner, M. M., 2421 Washington St.  
 Potter, C. D., 2904 Baker St.  
 Potts, J. S., 148 6th St.  
 Power, H. D'Arcy, 1801 Pacific Ave.  
 Powers, C. L., 1311 Bush St.  
 Powers, Geo. H., 1827 Pacific Ave.  
 Pressley, J. F., 300 Page St.  
 Preston, Walton, 1823 Fillmore St.  
 Preston, R. W., 430 Duboce Ave.  
 Pring, Ernest, 3003 Fillmore St.  
 Prosek, J. A., 829 Steiner St.  
 Purlenky, G. P., 2597 Mission St.  
 Putnam, V. E., 241 Devisadero St.

Quigley, J. M., 701 Clayton St.  
 Quinn, Clarence, 2298 Steiner St.  
 Quinn, 1542 15th Ave., South.

Rabe, B. A., 261 4th Ave.  
 Ragan, D. P., 1299 Haight St.  
 Rea, C. T., 486 Haight St.  
 Read, J. M., 352 Devisadero St.  
 Read, W. P., 1309 Pine St.  
 Records, Edward, 1344 Fell St.  
 Regensburger, A. J., 15 7th Ave.  
 Regensburger, M., 3242 Clay St.  
 Redding, G. H., 115 Adams St., Oakland.  
 Renz, Carl, 2504 Clay St.  
 Rethers, Theo., 2271 Jackson St.  
 Retsloff, E. H., 2504 Clay St.  
 Reynolds, H. B., 210 Leucost St.  
 Rice, Ph., 2428 Bancroft way, Berkeley.  
 Richardson, G. H., 2917 Clay St.  
 Richter, Dr. C. M., 2108 Scott St.  
 Richter, Conrad, 1301 Golden Gate Ave.  
 Rigdon, R. L., 2101 Webster St.  
 Riley, W. C., 1796 Post St.  
 Rinne, F. A., 2901 Folsom St.  
 Rivas, Isaac, 1255 Octavia St.  
 Reynolds, Harry, 2510 Washington St.  
 Rixford, E., Lane Hosp., cor. Clay & Webster Sts.  
 Roberts, H. P., 31 Parnassus Ave.  
 Robertson, J. W., 2510 Washington St.  
 Rochex, Jos., 2700a 24th St.  
 Roche, H. N., 1203 Buchanan St.  
 Roche, T. B., 569 Haight St.  
 Rogers, Nathan, 1722 Fillmore St.  
 Rooney, H. T., Lane Hospital.  
 Rosenberg, Caroline, 2900 Jackson St.  
 Rosenerantz, N., 1323 Devisadero St.  
 Rosenstirn, J., Mt. Zion Hospital & 1625 Sutter St.  
 Rosenthal, Ch. H., 636 Baker St.  
 Rosenthal, A. G., 21 Scott St.  
 Ross, F. W., 2496 Sutter St.  
 Retchild, Max., 902 Devisadero St.  
 Ryfkoegel, H. A. L., 1518 Masonic Ave.  
 Rothschild, Max., 902 Devisadero St.  
 Rottanzl, T. A., 135 Belvedere.  
 Rulofson, A. C., 2253 Union St.  
 Rulofson, A. C. Jr., 2253 Union St.  
 Rumwell, M. E., 719 Ashbury St.  
 Russell, Tracey, 1299 Page St.  
 Ryer, M. B., 2790 Pine St.

Salomon, Max, 1109 Franklin St.  
 Sampson, A. F., 1942 Webster St.  
 Sanborn, B. L., 1860 Buchanan St.  
 Sanborn, F. G., Clark Barton Hosp., 1360 Post St.  
 Sanders, J. S., cor. Jones & California Sts., (rents)  
 Sankey, M. J., 274 San Carlos Ave.  
 Sartori, H., 2105 Union St.  
 Sawyer, H. C., 1228 McAllister St.

Scheu, R. E., 1314 Webster St.  
 Schirman, M., 1620 Post St.  
 Sawyer, H. C., 1228 McAllister St.  
 Schloss, A., Ellis and Devisadero Sts.  
 Schmolz, Ch. J., 3608 16th St.  
 Schmeltz, Ch. J., 20 Steiner St.  
 Schmitt, L. L., 316 Maple St.  
 Schmoll, E., 2411 Fillmore St.  
 Scholtz, W. H., 1223 47th Ave.  
 Schwarz, J., 2971 Clay St.  
 Scott, Catherine, 1386 Haight St.  
 Scott, R. T., 2737 Howard St.  
 Sehorn, W. A., 1609 Broderick St.  
 Sechrist, Ch. J., 2129 Bush St.  
 Seibe, Elizabeth, 406 Central Ave.  
 Selfridge, Grant, 1732 Broadway.  
 Selling, Mathalie, 1961 Pine St.  
 Selzer, M. J. E., 2014 Peralta Ave., Fruitvale.  
 Serviss, Th. W., 1176 Fulton St.  
 Seymore, J. H., 4093 24th St.  
 Sheldon, J. W., 2431 Channing Way, Berkeley.  
 Sherman, Harry, 2125 Jackson St.  
 Sherrod, L. L., 1175 23rd St., E. Oakland.  
 Shiels, Wilson J., 2175 Pacific Ave.  
 Shirley, J. H., cor. 4th Ave. & Fulton St.  
 Shoemaker, D., 303 6th Ave.  
 Short, E. N., 2527 Van Ness Ave.  
 Shumate, Th. E., 2707 California St.  
 Silverberg, M., 1807 Gough St.  
 Simon, J. A., 2344 Sutter St.  
 Simon, Martin, 2701 Sacramento St.  
 Simon, M. E., 2431 Washington St.  
 Simons, H. N., 2900 Fulton St.  
 Simpson, J. A., 612 20th St.  
 Simpson, F. W., 2677 Mission St.  
 Slorich, J. F., Cal. Woman's Hosp., 3118  
 Sacramento St.  
 Sisson, E., 2238 Vallejo St.  
 Smith, C. L., 1015 Leinen St., Oakland.  
 Smith, Ethan H., 2617½ Octavia St.  
 Smith, F. H., 2212 Sutter St.  
 Smith, J. F., 265 Page St.  
 Smith, John Wm., 1196 Kentucky St.  
 Smith, L. A., 1546 Ellis St.  
 Smith, R. W., 903 Ashbury St.  
 Smith, J. R., 2510 Washington St.  
 Smith, Ordo, 502 Valencia St.  
 Smph, R. K., 2600 Jackson St.  
 Sobey, A. L., 2480 Mission St.  
 Sotclay, Jul., 670 Fulton St.  
 Someis, Geo. B., 2662 Vallejo St.  
 Somers, Howard, 1018 Page St.  
 Southard, W. F., 1914 Pine St.  
 Snyder, Geo. S., 901a Stanyan St.  
 Spalding, A. B., 2303 Scott St.  
 Spencer, John C., cor. Gough & Turk Sts.  
 Spiro, H., cor. Geary & Octavia Sts.  
 Sponogle, F. M., 1077 Page St.  
 Sprague, Frances, 2418 Washington St.  
 Spriggs, L. W., 763 Haight St.  
 Stafford, D. E., Sacred Heart Church.  
 Stapler, D., German Hospital.  
 Starbord, G. A., 655 Shotwell St.  
 Starr, F. R., 1121 Devisadero St.  
 Steizner, E., 1234 Geary St.  
 Stephens, W. B., 1121 Devisadero St.  
 Stark, B. W., 2398 Union St.  
 Stern, J. S., 1734 Page St.  
 Stern, Louis, Mill Valley, care Mrs. Doherty.  
 Stevens, W. E., 1007 Fillmore St.  
 Stillman St., 2201 Buchanan St.  
 Stierwalt, H. W., 702 Oak St.  
 Stokes, T. P., 1604 Haight St.  
 Stone, Bert, 404 Jersey St.  
 Stone, J. S., cor. Ellis and Gough Sts.  
 Stone, F. P., cor. Ellis and Gough Sts.  
 Stark, Dr. Bertha Wagner, 2398 Union St.  
 Stoney, R. C., 2209 Sutter St.  
 Stowell, J. M., 596 Haight St.  
 Stratton, W. C., 1504 Franklin St., Oakland  
 Strickland, S. L., 2500 Fillmore St.

Sullivan, John F., 3476 17th St.  
 Sweeney, Geo. J., 1159 Masonic Ave.  
 Swett, W. H., 2417 Washington St.  
 Taggart, T. E., 402 Locust St.  
 Tait, Dudley, 1879 Sutter St.  
 Taylor, A. H., Fresno.  
 Taylor, A. Miles, 1914 Pine St.  
 Taylor, Alonzo E., 2515 Octavia St.  
 Temple, Flor., 1531 Geary St.  
 Terry, W. I., 2019 Pacific Ave.  
 Terry, S. P., 1602 Haight St.  
 Terrill, Geo., 1732 Washington St.  
 Thiele, E., 472 8th St., Oakland.  
 Thomas, F., 810 Turk St.  
 Thomas, P. M., 2510 Washington St.  
 Thomas, W. E., 2235 Post St.  
 Thompson, E. W., 1433 Haight St.  
 Thompson, G. H., 697 Haight St.  
 Thompson, J. E., 200 4th Ave.  
 Thorne, I. W., 1434 Post St.  
 Thorne, W. S., 460 Duboce Ave.  
 Thorwick, Martha G., 460 Duboce Ave.  
 Thrasher, Marion, 881 Fulton St.  
 Tillman, F. J., Receiving Hospital.  
 Tisdale, R. F., 440 Devisadero St.  
 Tobriner, Oscar, 1800 Sutter St.  
 Todd, D. B., 1200 Railroad Ave.  
 Tomlinson, R. F., 2446 Jackson St.  
 Topping, F. J., 1826 Vallejo St., 1-3.  
 Torello, E. N., Mission road and Silver Ave.  
 Townsend, John, 1001 Valencia St.  
 Toye, W. O., 1628 Lake St.  
 Trask, S. H., Geary and Octavia Sts.  
 Troppman, Ch., 2863 16th St.  
 Tryon, W. M., 1932 Fell St.  
 Tuchler, A. S., 703 Van Ness Ave.  
 Tuggle, S. P., 2214 Steiner St.  
 Vandre, H., 2925 San Jose Ave.  
 Vassault, Theodora, 2117 Washington St.  
 Villain, A. J., 2125 Cedar Ave., Berkeley.  
 Van Dyke, E. C., 2112 Steiner St.  
 Van Meter, M. E., 140 6th Ave.  
 Veale, A. F., 657 Haight St.  
 Veckl, V., 1523 Laguna St.  
 Voje, Jul., 757 14th St.  
 Vogel, T. A., 2602 Howard St.  
 Vonanburgh, J., 1626 Turk St.  
 Von Buelow, 753 Alabama St.  
 Von der Lieth, 2929 Steiner St.  
 Von Hoffman, Dr. C., 2611 California St.  
 Von Wethern, J., 1501 Church St.  
 Voorhies, A. H., 2111 California St.  
 Voorsanger, Wm., 3032 Washington St.  
 Vowinkel, F. W., 1200 Octavia St.  
 Wahl, H. A., 1703 O'Farrell St.  
 Wakefield, W. F. B., 2609 California St.  
 Wagner, Henry L., 2339 Bush St.  
 Wagner, John, 297 Church St.  
 Wakefield, W. F. B., 2609 California.  
 Waldeyer, Wm., 2210 Devisadero St.  
 Wallgren, Dr., City and Co. Hospital.  
 Waller, C. B., 1845 Fillmore St.  
 Waller, J. L., 2154 15th St.  
 Walsh, Wm., cor. Laguna St. and Ivy Ave.  
 Walworth, Ch. H., 5411 Genoe St., Oakland.  
 Wanzer, Lucy, 1220 Geary St.  
 Ward, Flo., 2700 Broadway.  
 Ward, J. W., 2401 Scott St.  
 Wardlaw, H. J., 2510 Washington St.  
 Warren, H. C., Cal. Woman's Hosp., 3118  
 Sacramento St.  
 Watanabe, K., 1304 Post St.  
 Watkins, J. T., 2418 Washington St.  
 Watson, Dorothea, 2851 Clay St.  
 Watson, Flora Reeves, 3020 Clay St.  
 Webster, Fred F., 1263 Laguna St.  
 Weil, Conrad, 2125 Bush St.  
 Weis, A. H., 1546 Ellis St.

- Weiss, E. M., 240 Clay St.  
 Weston, F. R., 2721 Channing way, Berkeley.  
 Weeks, A., 212 Spruce St.  
 Weeks, A., 212 Spruce St.  
 Wells, Edith, 2126 Bush St.  
 Werenburg, 21 Baker St.  
 Welty, Cullen, 2510 Washington St.  
 Wempel, E. L., Jr., 2510 Washington St.  
 Wemple, E. L., 1952 Ellis St.  
 Werner, A. F., 1797 McAllister St.  
 West, E. F., Glen Ellen, Sonoma Co., Cal.  
 Westerfield, O. F., 114 Masonic Ave.  
 Weston, F. R., 1169 Broadway, Oakland.  
 Westphal, E. W., 1109 Franklin St.  
 Wheeler, Albert, 2238 Bush St.  
 Weyer, G. A., 1137 Devisadero St.  
 Whitney, J. D., 2229 Sutter St.  
 Whitman, Ch. H., 1607 Fillmore St.  
 Wiborn, A., 1969 Sutter St.  
 Wilhelm, A., 1969 Sutter St.  
 Willard, W. P., 2672 Pine St.  
 Williams, Francis, 1392 Haight St.  
 Williamson, J. M., 1631 Oak St.  
 Williamson, W. L., 98 Webster St.  
 Willits, E. K., 2418 Washington St.  
 Wilson, F. P., 2245 Sacramento St.  
 Wilson, G. B., 504 Haight St.  
 Wilson, H. F., 3765 17th St., 1-3.  
 Wilson, M. Th., 1666 Fell St.  
 Winterberg, W., 1813 Laguna St.  
 Winterberg, W. H., 2926 Pine St. and Gen. Hosp., Preside.  
 Wise, Sarah, 625 Ashbury St.  
 Wood, G. A., 2588 Pine St.  
 Woods, Alice, 2418 Washington St.  
 Woodward, A. P., 312 Haight St.  
 Woolf, M. J. H., 1653 Oak St.  
 Woolsey, Ch. H., 2229 Sacramento St.  
 Woolsey, Mark H., 1278 Fulton St.  
 Worth, Sidney, 1721 Vallejo St.  
 Worthington, Geo. B., 2411 Pacific Ave.  
 Wreder, J. E., 2600 Sutter St.  
 Wright, A. H., 1234 McAllister St.  
 Wyckoff, Lydia, 2525 Durant Ave., Berkeley.  
 Wymore, W. W., 2534 Mission St.  
 Yeargain, O. W., 4421 J. St., bet. 45th & 46th Aves.  
 Yetter, C., 3398 18th St.  
 Young, L. H., 2327 Market St.  
 Young, H. G., 2614 Buchanan St.  
 Younger, E. A., 2735 Clay St.  
 Zabala, J. L., 453 Duboce Ave.  
 Zobel, A. J., 352 Lake St.  
 Zumwalt, F. H., cor. Fillmore & Washington Sts.  
 Zussman, S., 1437 O'Farrell St., 1-3.

—Pacific Medical Journal.

## BOOK REVIEWS.

**BLAKISTON'S QUIZ-COMPEND. A COMPEND OF MATERIA MEDICA, THERAPEUTICS AND PRESCRIPTION WRITING.** With especial reference to the physiological action of drugs based on the eighth revision of the U. S. Pharmacopoeia, including also many unofficial remedies. By Samuel O. L. Potter, M.D., M. R. C. P., Lond., formerly professor of the principles and practice of medicine in the Cooper Medical College of San Francisco; author of "Materia Medica, Pharmacy and Therapeutics," "Quiz-Compend of Anatomy," "Index of Comparative Therapeutics," and "Speech and Its Defects," late Major and Surgeon of Volunteers, U. S. Army. Seventh edition, revised and enlarged; 292 pages. Philadelphia; P. Blakiston's Son & Co., 1012 Walnut street, 1906.

This book being intended chiefly for medical students, the essentials of the physiological action of drugs and the therapeutic science have been briefly but well stated. An evidence of the popularity of this compend is the fact that the present edition is the seventh that has been brought out.

**INTERNATIONAL CLINICS.** A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhin-

ology, laryngology, hygiene, and other topics of interest to students and practitioners. By leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia; U. S. A., with the collaboration of Wm. Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; Jas. Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; Thos. M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna; with regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipzig, Brussels and Carlsbad. Volume II. Sixteenth series, 1906, 302 pages. Philadelphia and London, J. B. Lippincott Co., 1906. Price, cloth, \$2.00 net.

This is Volume II of the Sixteenth Series of the International Clinics, edited by A. O. J. Kelly of Philadelphia, with the collaboration of some of the best American and foreign practitioners. The articles under the various heads of treatment, medicine, pediatrics, neurology, surgery, obstetrics, gynecology and laryngology are well written, and here and there of more than passing interest. The illustrations and diagrams are exceptionally good.



CONSUMPTION—ITS RELATION TO MAN AND HIS CIVILIZATION; ITS PREVENTION AND CURE. By John Bessner Huber, A.M., M.D., Fellow of the New York Academy of Medicine; Member of the National Association for the Study and Prevention of Tuberculosis; Visiting Physician to St. Joseph's Hospital for Consumptives; Member of the Advisory Board, The New Mexico Cottage Sanatorium, etc. Philadelphia and London: J. B. Lippincott Co.

The author of this book aims to deal with the question of tuberculosis in a manner which is of interest to both laymen and the medical profession.

The effects of tuberculosis upon the state, the family and the individual are all carefully considered and the part of each one of these in overcoming the disease is clearly pointed out.

The author has dwelt strongly upon the deleterious influence of this disease upon the race, and urges the necessity for its early control.

The portions of the book dealing with the sociological and humanitarian aspects of tuberculosis are especially strong; much stronger than those dealing with the scientific problems, although the latter have been well considered.

In dealing with the subject of the relation between physician and patient he justly emphasizes the strength necessary upon the part of the physician and the necessity of the patient's obedience. He is too pessimistic, however, in the following: "Knowing that benefit is a matter of months, arrest of years, cure of many years, he (the physician) will map out the course accordingly." While much harm can be done by using the terms "arrest" and "cure" too loosely, surely the author would not wish to overdraw the difficulty of arriving at satisfactory results.

On page 199 the sentence: "The consumptive patient will be careful not to reinfect himself, to which end he must associate intimately as little as may be with other sufferers," is unfortunate; especially in a book which is intended for both lay and professional readers and one which is advocating the sanatorium treatment of this disease. There

is no place freer from danger of infection than a well-conducted sanatorium. A tuberculosis patient is not necessarily dangerous. If he takes the proper precautions there is no danger in associating with him.

The paragraph dealing with the tuberculin test is very unsatisfactory. He says: "In the tuberculous, reaction occurs with 0.001 c.c. and declares itself within four or five hours by general symptoms,—rise of temperature to 102-104 deg. (usually after a preliminary chill), pain in the limbs, weariness, cough, often nausea and vomiting, occasionally cerebral symptoms. These last about half a day. There are also local reactions—externally redness, swelling, exudations—which subsequently harden into crusts and scabs and fall off; pulmonary foci give rales, increase of dullness, of cough and expectoration, and perhaps tubercle bacilli in the sputum."

The difficulty with this statement is that one milligram will not give a reaction as a rule. According to the case, from one to ten milligrams may be required. If a small dose is given and then a larger one the second day following, and a third, larger, three days later, as a rule, the disease may be detected without such severe symptoms as are here noted. A diagnosis can be made by one who is familiar with the use of tuberculin just as well with a temperature reaction of 100 deg. or 100.5 deg., with slight malaise or aching as with the severe symptoms here mentioned. The advent of these symptoms is usually from eight to twenty-four hours after the dose, instead of four hours as mentioned.

The importance of organization is strongly urged, dispensary and sanatorium treatment are strongly commended.

The book deals with tuberculosis in all its various aspects. It abounds in useful information, and I take pleasure in recommending it as a useful book for those who are interested in the warfare against this disease. F. M. P.

## THERAPEUTICAL HINTS.

Dr. George Thomas Palmer, managing editor of the *Chicago Clinic and Pure Water Journal*, is preparing a work upon "Mineral Springs and the American Waters Used Medicinally." He is now holding the files for final revision. All those interested in the accurate listing of California Springs should communicate with the *Chicago Clinic and Pure Water Journal* at once. Address all communications to Springfield, Ill.

\* \* \*

The Nauheim treatment at home is a great desideratum. Send to David M. Fletcher, P. O. box 272, Vallejo, Cal., and get literature and samples of the Triton Effervescent Bath Salts, for the Nauheim treatment. Theo Schott, in the *New York Medical Record*, February 14, 1891, says: "I am convinced by many experiences that identical results may be achieved by artificially prepared Nauheim baths."

\* \* \*

Our Elixir (Somnos) contains in each 16 c.c. 1.2 gm. of a concentrated (7.5 per cent.) trichlorethidene propenyl ether solution in glycerin. When 10 c.c. of this elixir is injected into the veins of a dog or other animal, the immediate effect is no greater than the effect of injecting the same amount of normal salt solution in the same way, and not until total doses corresponding to twenty times that prescribed does the blood pressure show any permanent fall, or decrease in respiration, and these phenomena are no greater than is characteristic of normal sleep. Trichlorethidene propenyl ether, as prepared by us in the form of elixir (Somnos), possesses all the desirable properties of chloral, but so far as known is free from its untoward effects. Physicians who know this to be the case (and a large and increasing number do know it) prescribe the product in preference to any other hypnotic, and their use of it is founded upon judgment and discretion.

\* \* \*

There is a reason for the popularity of Antiphlogistine, Antikamnia, Hayden's Viburnum Compound, and numerous other proprietaries. Whether many of these were "wonderful discoveries" or not, they have enabled the average physician to secure results more satis-

factory to himself and his patient than he was able to secure without them. Very, very few medical men are able to extemporize prescriptions which at the same time are effective, palatable and not uselessly polypharmaceutical. All doctors ought to be able to do this, but they are not—and whose fault is it? And even if they were, who but the sheerest crank would claim that he could properly write for, or the average druggist dispense, substitutes as elegant, as cheap, and withal so satisfactory as many of the best type of the proprietaries? It is best to look all these facts squarely in the face and be sensible in our conclusions.

\* \* \*

Labordine, the vegetable antipyretic, is a safe and reliable preparation to prescribe in all conditions where an antipyretic is indicated. It is a vegetable product, and therefore is free from all of the objectionable qualities of the mineral preparations, while possessing the necessary healing properties. No heart depression follows its use, no habit formation and no bad after effects. Samples will be furnished on request. Labordine Pharmacal Co., St. Louis, Mo.

\* \* \*

SAUNDERS' NEW BOOKS:—Messrs. W. B. Saunders Company announce for publication in the early fall the following excellent and practical works: Keen's Surgery; Its Principles and Practice (Volume I). Sobotta and McMurrich's Human Anatomy (Volume III). Webster's Text-Book of Gynecology. Hill's Histology and Organography. McConnell's Pathology. Morrow's Immediate Care of the Injured. Stevenson's Photoscopy (Retinoscopy and Skiascopy). Prieswerk and Warren's Atlas of Dentistry. Goepf's State Board Questions and Answers. Lusk's Elements of Nutrition. The most notable announcement is the new work on surgery, edited by Dr. W. W. Keen, complete in five octavo volumes, and containing over 1500 original illustrations. The entire work is written by the leaders of modern surgery—men whose names are inseparably associated with the subjects upon which they have written. Without question, Keen's Surgery will represent the best surgical practice of today.

# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## VIENNA.

### ITS OPPORTUNITIES FOR POST-GRADUATE WORK.

By DUDLEY FULTON, M. D., Los Angeles.

Vienna, the fourth city in Europe, with a population of 2,000,000, has been the leading foreign post-graduate center for over four decades. If the number of post-graduates is a proper criterion with which to offer comparison, Vienna may still be regarded as the most important medical center in Europe. Other clinics on the Continent, notably Berlin, Leipzig, Strassburg, Bern, Munich, and Heidelberg, are attracting many physicians who desire work along certain lines in which the clinics and the professors conducting them are well known, but it would be an error to assume, therefore, that Vienna is less popular and influential than formerly.

Physicians who are doing special work here in Vienna are very enthusiastic over their opportunities and instruction, and several who had spent several weeks or months elsewhere say they regret that they did not come to Vienna earlier.

The existing civil and social conditions of Europe, which entail such abject poverty among the masses, create conditions quite different from those in the large American cities. Hospital conditions are also different. Here, poverty

is too great to permit the care of the sick in private homes. The hospital wards are filled to overflowing with rare and interesting cases.

Another feature which adds much to the value of European clinics is that powerful influence which authority plays in the lives of the lowest classes. Here the Church and the civil powers rule and mould their subjects to a degree which an American can hardly appreciate. Those in authority are absolutely dominant. This authority carries into medicine. The professor is a being with authority. He is a very big thing and is respected and obeyed without question.

As a side light on this very interesting influence, it is worth while to relate that all of the surgery, both private and in the hospitals, in this city with two millions of inhabitants, is controlled by eight or ten men. Why? Because no one needing so "important" a thing as an operation would think of having any person but a professor do it. If the patient is rich, he pays richly for it; if he be poor, he can go to the general hospital where a professor or his assistant



does it for nothing. Incidentally, it may be of interest that the annual income of these professors of surgery amounts to from fifteen to fifty thousand dollars a year, while the average general practitioner on the outside is lucky if his annual income amounts to three or four per cent. as much.

In a Vienna hospital a patient considers it an honor to be demonstrated in a clinic by a professor. The patients do not object in the least to being persecuted and examined daily by anybody who will go to the trouble to do it. It is not at all unusual to see ten or a dozen Americans following, for example, an aortic aneurysm from the clinic to the ward, stethoscopes in hand. The abundant clinical material is freely accessible to post-graduates, to a degree not found in the American charity hospitals, and not even in most of the continental hospitals, because of various restrictions and conditions. In Berlin a few years ago the Socialist party, which considered this excessive amount of examination of the patients as an injustice and hardship to the latter, led in a successful boycott of the hospitals as a retaliatory measure. The dearth of clinical material which followed finally compelled the hospital authorities to compromise on a restricted and limited amount of examination of all charity cases. This measure still exists. In Vienna, fortunately for the post-graduates, there is practically no restriction, so long as the privilege is not openly abused.

Most of the American and other foreign physicians in Vienna spend most of their time in the laboratories and ward clinics of the famous *Krankenhaus*. In this immense hospital, which contains 2300 beds, and its outpatient department, over 100,000 patients are treated, and 7000 births occur annually. Over 3000 autopsies are held yearly. Every morning from 8 to 10:30 any graduate physician may go to the morgue and verify or correct the clinical diagnosis of any case which may have died. Probably

nowhere else in the world exists such an unrivaled opportunity for clinical and pathological comparison. For this reason, nowhere else can diagnosis in general medicine be studied to better advantage than in Vienna, with its abundance of material, and because of the easy access to it from the bedside to the autopsy table.

If the German school of medicine merits the reputation which it bears as to its excellency in the study of internal medicine and diagnosis, it is certainly due to the use which they make of the abundant clinical and pathological material. Autopsies may be compulsory in all cases and are subject entirely to the clinician's wishes. A few mornings in the autopsy room will convince anyone that the clinician is certainly hard after the pursuit of lesions and that sooner or later everybody in Vienna will go to autopsy.

The *Krankenhaus* is composed of the following clinics: Three medical, two each of surgery, gynecology, obstetrics, eye, skin and genito-urinary, and one ear, and one nose and throat.

Each clinic contains from 100 to 200 beds, and is under the absolute control of a professor. Each professor has a number of assistants, many of whom have international reputations.

The professors are appointed for life service by the government, and are paid large salaries. The selection of a professor to fill any vacancy which may occur is a very carefully considered matter. The selected man is always one of recognized ability and of well earned reputation. For instance, von Noorden assumes charge of the third medical clinic next month, succeeding Notlmagel, who died last year.

The professors hold general clinics daily which are free to all graduate physicians. The various assistants and associate professors conduct the private courses and ward clinics, which are so eagerly sought by the foreign post-graduate, as it is in these that he comes

into personal contact with patients and gets practical work in laboratories, etc.

The entrance into these private courses is controlled by the American Medical Association of Vienna. Over 300 foreign post-graduates study in Vienna every year. Ninety per cent. of these are Americans.

If one wishes to take a course in any subject, he registers his name to that effect. The rules of the Medical Association determine his eligibility. Places in these courses are governed by precedence; that is, the men longest here have precedence over later arrivals. If a new man wishes to take a course which is already full, the only way he can get into it is for an older man to create a vacancy by dropping out. If there are several new ones waiting for the place, the one who has been longest in Vienna gets the place. Formerly, a new arrival could buy or be given an older man's place in a course. This injustice to the men who had been waiting, perhaps weeks, for a vacancy, led to the present system, which is satisfactory and fair to all.

These private courses are limited to five, ten or twenty men, at the option of the one giving it.

Some of these courses are, naturally, more eagerly desired than are others; one or two are so popular that a man who does not become five or six months "old" has no chances of taking them. There are, however, several courses in the same subject offered at the same time, all given by experienced teachers. So the post-graduate, instead of waiting for courses, rather has difficulty in deciding which of the available courses to select.

The cost of these private courses varies from forty to eighty cents an hour for each man in the course. The man doing an average amount of work, therefore, pays out from \$75.00 to \$100.00 a month for tuition.

Living expenses are cheaper than in America.

A great advantage which Vienna has over many other medical centers is, that nearly all of the other hospitals, clinics and the polyclinic are within a radius of a mile from the Krankenhaus. Practically no time is lost going to and from the various clinics. Exceptionally good and cheap car service takes one within a few moments to the Franz-Joseph Hospital containing 900 beds; the Rudolph Hospital with 1000 beds; the Elizabeth Hospital with 600 beds; the Wiedner Hospital containing 800 beds; the Rothschild Hospital for Jews with 400 beds, besides several large hospitals for children, and various dispensaries.

In all of the above hospitals, arrangements may be made for post-graduate study, as in the Krankenhaus, under men of the first rank in medicine.

A very practical and important question to know, before coming to Germany to study, is the amount of German one must know to get much value from the work. In all of the clinics and lectures only German is spoken. The average American, if diligent, becomes able to understand the language fairly well and to receive some benefit from the clinics in from two to six months, according to his aptitude. The Americans who have been here longest say that never again will they advise anyone to come to Germany for post-graduate work who does not understand the language, or who is not prepared to remain at least six months.

Fortunately, some very good laboratory work may be had in English while one is studying his Deutsch, from a gentleman who has had as pupils scores of now well known American physicians.

Those who come for eye, ear, nose and throat work are greatly favored, as many of the men conducting these courses do so in English.

With these exceptions, therefore, it may be said that all the instruction, clinics and lectures, as well as everything else in Vienna, is German every minute of the time.

IX Kinderspitalgasse No. 1.  
Vienna, September 4, 1906.

## DRAINAGE.\*

## ITS IMPORTANCE IN ACUTE PELVIC INFLAMMATION.

BY H. S. GORDON, M.D., SANTA ANA, CAL.

No doubt everyone present realizes the importance of drainage for all purulent collections in any part of the body, and all practice it in most locations, but my observation leads me to make the statement that in pelvic inflammations the general practitioner does not drain either early enough or often enough. In fact his drainage is employed as a last resort. Why this is so I am unable to understand. Every physician knows that a purulent inflammation of the female generative organs is produced by the same pyogenic bacteria that produces it in other locations, hence must admit it is properly surgical and requires the same measures to relieve it as in any other location. This being the case, every case of acute pelvic inflammation that does not give evidence of subsiding in twenty-four hours under conservative treatment should be drained through the cul-de-sac. In no part of the body does infection make more rapid progress than in the lymphatics of the uterus and the surrounding structures, and many cases will not permit us to delay even twenty-four hours for conservative treatment, for in less time a fatal pyemia may be developed.

The moment a physician sees pus escape from the uterus he should feel anxious and the moment extension to the adnexa or peritoneum sets in his responsibility becomes great.

Pyosalpinx, pelvic, peritonitis, ovarian and broad ligament abscess rarely occur except through the medium of the uterus. A few cases occur through invasion from the intestines but they are rare.

Now occurring through the medium of the uterus it is reasonable that we should attack the primary focus. In all

purulent inflammations this should be done by thorough curettage and drainage through the natural course, the cervical canal. This drainage is the first important step toward the cure and prevention of extension of the infection. The swollen endometrium closing the cervical canal prevents natural drainage, hence favors the spread of the infection through the lymphatics.

If there is no evidence of the infection having passed beyond the uterus we may effect a cure without doing anything further, but if we have reason to believe that the infection has gone beyond the uterus we would be culpable to stop at this point. We should then open the cul-de-sac and drain the pelvic cavity.

If we wish to insure to our patient a fruitful future, if we wish to guard against future suffering from adhesions or recurrent inflammations, if we wish to avoid future oophorectomies, hysterectomies and other capital operations we must open the cul-de-sac, liberate adhesions and drain off the muddy toxin-laden serum being poured out by the lymphatics. If this was done in all such cases the operative work of the gynaecological specialist would decrease fifty per cent. for they will tell you that a large portion of their operative cases comes from that class that were improperly treated in the acute stage of the disease.

But, says one, why drain all these cases, do not a great many recover without? Well they certainly do not all die during the acute stage who are not given drainage, but the vast majority of them only partially recover. That is, they get out of bed, are discharged by the physician and are pronounced cured;

\*Read at the Thirty-sixth Regular Semi-Annual Meeting of the Southern California Medical Society, Arrowhead Hot Springs, May 2, 1906.



but watch them and in a short time you will find them complaining of the pain, dragging sensations, constipation and that long train of symptoms arising from pelvic adhesions, it may be have recurrent attacks of oophoritis, salpingitis or localized peritonitis and they are far from well.

One of the principal reasons why I advocate early drainage is that the clinical picture does not always tell you what the final result may be. A fatal sapremia may not produce marked constitutional symptoms at the beginning yet your patient may die in forty-eight hours from the initial chill, or the streptococci may be rapidly invading the tissues outside the uterus and a fatal peritonitis result. After the pus has formed outside the uterus the most conservative would institute drainage, but why wait for this and risk the chance of septicemia, pyemia or general peritonitis? Why not drain earlier and avoid this risk to our patient? If we did we would reduce our mortality in such cases to a minimum.

I am aware of the fact that many physicians tell us we should not have puerperal sepsis under our system of aseptic and antiseptic management of labor; this statement may be true in hospital practice but in private practice it will not hold good; the theory is good but practically we know such cases do occur and we must treat them.

Six years ago I read a paper advocating drainage in puerperal sepsis. Several physicians present were very positive in their assertions they did not have sepsis in their cases. In less than six months I was called in consultation in two cases of puerperal sepsis and both cases were under the care of physicians who had scouted the idea of puerperal infection in this enlightened age in discussing my paper.

Only a few weeks ago a physician reported to me a case of this sort saying the uterus had been curetted and irri-

gated at the beginning of the infection; twenty-four hours after there being no improvement the patient was again anaesthetized and the endometrium thoroughly gone over with the finger after which it was again irrigated; yet another twenty-four hours had elapsed and no improvement except as he said a drop in the temperature, which is no indication of improvement in such cases. I advised drainage through the cul-de-sac stating to him that the lack of improvement was strong proof that the infection had gone beyond the uterus. My advice was not heeded and the woman died. Here the progress of the infection was not rapid, for she lived three weeks after the infection began.

Now after the curettage failed to produce results, if the cul-de-sac had been opened, adhesions freed, the lymph spaces opened and proper drainage instituted with iodoform gauze, the woman would have recovered, for it was not one of those rapidly fatal cases. But with these pathogenic bacteria shut up in the pelvis with no chance for escape and every environment favorable for their multiplication what would be reasonable to expect as regards results? Had this been an abscess in the axilla either physician of the two in attendance would have incised and drained it. Why not do the same when the pus is in the pelvis?

These cases cannot be cured by treating the uterus alone. Understand me, I think it is important to treat the uterus so as to drain the pelvic cavity, this being the primary focus of infection, and it is here the invasion begins and it is here we must begin the fight. Not as of old with the opium poultice and douche treatment but with the curette, antiseptics and most important, gauze drainage through the cervical canal. I am aware of the fact that a great deal has been written of late condemning the use of the curette and telling of the great danger in its use but I still think it an im-

portant instrument in the treatment of purulent inflammation of the endometrium, while there have perhaps been a few cases where harm has been done with it, when we come to consider the fact that it is used in almost every village and hamlet in the whole civilized world I think the record of its use will bear favorable comparison with any other instrument in any other operation of like gravity. In fact it is the contempt for danger which the familiarity of frequent use brings that perhaps causes trouble from its use.

I have taken puerperal infection as my example in this paper but the same rule is applicable in the infection of the uterus, whether it follow labor, abortion, infection from gonococci or any source that produces acute purulent infection in this region. When we open the cul-de-sac and introduce a finger we find recently effused lymph, the rectum often attached to the posterior surface of the uterus, the inflamed tubes sealed to whatever structures they may lie in contact with and the lymphatics pouring out a muddy serum loaded with bacteria. We are enabled at this time to break up these tender adhesions, open the lymph spaces and by packing the pelvis with iodoform gauze prevent further adhesions and with the free iodine liberated from the iodoform inhibit the further growth of the bacteria, and the amount of these bacteria you will find in the serum that is drained off in this way will be sufficient to convince the most skeptical of the necessity of the procedure.

\* \* \*

#### DISCUSSION OF DR. GORDON'S PAPER.

DR. FRANK GARCELON, Panama.—In the past the rule had been that "when in doubt, drain." But clinical experience had shown that many cases do as well without as with drainage. The drain itself did not protect so much as did nature's throwing out of plastic exudate.

\* \* \*

DR. A. S. ROUFFLEUR, Chicago.—Pus in pelvis acted differently than in other parts of the body. The use of a curette was to

dilute. In lower pelvis, much pus could be present without fatal sepsis. Gauze in cul-de-sac leads to adhesions that are not so thick and firm; hence they can be handled more easily. He himself preferred a tube drain to gauze. In more acute conditions, preferred to operate from above.

\* \* \*

DR. W. W. BECKETT, Los Angeles.—In acute infection of the uterus, he established drainage at once and then let uterus alone. Irrigation several times daily would only keep up sepsis. A gauze drain through cervix stopped drainage for twenty-four hours, and drainage was obtained only after its removal. Nor would he open the cul-de-sac before pus was formed. Infection would only be sequestered. Could not see the advantage of gauze packing at this time. Patient in bed and the expectant treatment was better at this stage. When pus was present, would drain, but with tube rather than with gauze.

\* \* \*

DR. C. D. BALL, Santa Ana.—Where sepsis followed delivery, the sterilized hand and finger was the curette to use and was preferable to incision and drainage of the cul-de-sac. Cited three cases with fatal termination following incision which had come under his observation.

\* \* \*

DR. Z. T. MALABY, Pasadena.—Dr. Beckett's remarks were opposed to the teaching of Dr. Peyer, who favored early opening of the cul-de-sac. In an early case, he curetted digitally, washed with boric acid solution and packed with 5 per cent. iodoform gauze.

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DR. JNO. C. KING, Banning.—He would drain for pus, but not for an abscess. Followed in the practice advocated by Dr. Beckett. Preferred curette carefully used to finger, since it traumatized less. After abscess had been removed, he kept his hands off. Packing the uterus inhibited drainage. Preferred drainage and expectant treatment to opening the cul-de-sac. Gauze did not drain so much as it caused formation of adhesions. Believed radical operation transformed minor into major cases.

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DR. W. W. HITCHCOCK, Los Angeles.—In a case of puerperal septicaemia, if chill came on after curettage and drainage, he would curette. Felt he had saved lives by repeatedly curetting in such cases.

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DR. H. S. GORDON, Santa Ana.—Did not recommend frequent irrigation of the uterus. If an improvement in 24 hours, then as Dr. Malaby had stated, infection had not been done away with and opening of cul-de-sac was indicated. To wait for general infection and then open cul-de-sac was useless. We should liberate serum that contains germs before they really form pus.

## MENINGITIS.\*

## THREE CASES WITH PECULIAR EAR SYMPTOMS.

BY W. H. ROBERTS, M.D., PASADENA, CAL.

These cases with their post-mortem findings are reported in the hope that what is learned may be of benefit to us all, and particularly that from the last two we may learn to look earlier for symptoms of meningeal involvement.

The first is chiefly of interest because the autopsy so clearly confirmed the diagnosis made over a month before death, and because of the remarkable condition found in the middle ear.

The last two, I think, teach among other things, that we should never examine an ear with an acute otitis media without keeping ever before us the possibility of a meningitis developing in spite of the proper treatment being instituted. We should, therefore, always be guarded in our prognosis in all acute middle ear inflammations.

CASE I.—On January 20th, 1905, W. H., age fifty, came under my care bearing the following letter from his physician in the country.

*"Dear Doctor:* The bearer came to me about two months ago with neuralgic pains in and about the left ear and brow, and in a general run-down condition, which I attributed chiefly to a very septic condition of the mouth. He has had the pains off and on since that time, has continued weak and hardly gains at all. About a week or ten days ago swelling, slight redness and tenderness on pressure over the mastoid tip came on. There has, at no time, been any discharge from the ear. Evening temperature has been slightly raised for some time and pulse about 100. Deafness was about complete when he came to me, although he says he had quite recently received telephone messages with that ear. Watch tick audible about eight inches on the other side, but today

it is almost deaf to watch tick. I blistered over mastoid twice when he first came to me."

On examination I found the entire mastoid tender, considerable edema of the tip and neck, drum dull, thickened but not in the least congested. No evidence of perforation, no sagging of the canal, very marked degree of deafness. Temperature 99.8.

Diagnosis.—Mastoiditis with Bezold perforation of the tip.

I advised patient to go immediately to the hospital and expected to operate that evening. The patient consented but expressed a wish to return home for an hour or two in order to attend to some necessary business before going to the hospital. Nothing more was seen of him until on the morning of the 24th of February when a telephone message was received from his home in the country saying that he was in a very bad condition—dying, it was feared. On my arrival there I learned that the man had been losing ground steadily for some weeks although complaining less and less of pain around the ear until within the last two or three days, when he remained in bed most of the time with hot applications to the ear. The morning before he complained of very severe pain in the small of his back, which he had injured some years before by being thrown out of a buggy. Toward evening he became rather irrational with a slow pulse in the neighborhood of 60. All night he was exceedingly restless and on the morning of the 24th he could only be aroused with difficulty. I found skin cold and clammy, patient groaning, throwing himself from side to side in the bed, and at times holding his hand to his fore-

\*Read before the Western Section of the American Laryngological, Rhinological and Otolological Society, Los Angeles, January 27, 1906.



head and left ear. Pressure over the mastoid made him wince, and on asking if it hurt he replied "yes," the only intelligent answer obtained. There were no facilities in the house for making a satisfactory examination, but because of the slow pulse I thought there was the possibility of brain abscess, and as the sons wished to take the chances of an operation, I had the patient taken to the hospital in an ambulance where I saw him at 5 o'clock with Dr. Hill Hastings of Los Angeles. Temperature 102, pulse 100. The entire condition had changed, patient then showing signs of active meningitis. Lumbar puncture obtained turbid serum which contained the pneumococcus. I refused to operate and put an ice pack to his head. Patient died at 5 o'clock the morning of the 25th.

Autopsy.—That evening, performed by Dr. Stanley P. Black and myself. Found a diffuse purulent leptomeningitis, most intense at the base of the brain. No signs of abscess. The dura was exceedingly adherent over the left temporal bone, particularly over the I found it filled with pus as were all of the mastoid cells, which had practically broken down, forming one large cavity. The probe passed readily through the perforation at the tip of the mastoid and three inches into the neck. After removing the softened superior wall of the attic, the middle ear was found entirely normal and dry, mucous membrane not adherent, it stripping readily from the bony walls, and the ossicles in good condition.

This man's life was sacrificed by his pig-headed determination not to go to the hospital, or submit to an operation. After his return home his physician and his sons tried to persuade him to follow my advice but without avail.

CASE II.—Miss L. H., age 25, occupation, dressmaker.

I first saw her at 9 p.m., August 7th, 1903, by request of Dr. A. T. Newcomb, and the following history was obtained.

For over a year had had spells of dizziness, worse particularly the past month. One month prior to this she had fainted. For four weeks she had had a great deal of pain in her back and had been under a physician's care for sciatic rheumatism. During the latter part of this time she had been running some temperature. On the morning of August 1st she had shampooed her hair and that day some tonsillitis set in. On the fifth she called at Dr. Newcomb's office for treatment of her tonsils. That morning she had some neuralgic pains in her right ear. In the evening the pains became very severe in the ear and over that side of her head. By ten o'clock the pains had begun to quiet and the following morning the ear began to discharge some straw-colored serum. From that time on she had no more pain in her ear.

I was called by Dr. Newcomb to see the patient because of some mastoid tenderness. Examination revealed the following:

The patient was exceedingly nervous. The muscles of the right side of the neck were quite tender, but very slight mastoid tenderness. The external auditory canal contained some whitish flakes which were removed by syringing. The drum was exceedingly congested and thickened so that I was unable to make out the land marks. The middle ear was full of straw-colored serum (no pus) which was removed by Politzer inflation and pneumatic speculum. This improved her hearing and made her feel more comfortable. The patient also complained of very severe pain in the back of her neck, in the cervical region, and severe frontal headache. The pupils were normal. The ear was dressed with cotton wick containing glycerine and carbolic acid. On the following morning I learned that the patient did not sleep until about 3 a.m. She had had no pain in the ear since the treatment. The cotton pad outside the wick was wet with straw-

colored serum, no secretion in the canal and none came from the middle ear by Politzer inflation, or pneumatic speculum. She was complaining of intense pain in the cervical and lumbar regions and also the frontal region of her head. She had some abdominal tenderness. Temperature 102.6, pulse 96, pupils normal. The patient looked very sick and was removed to the hospital for better treatment than she could receive at her home. 2:30 that afternoon at the hospital, she seemed to be in a condition of collapse. Her features were drawn, pulse weak, temperature 103.8 (rectal). Found a slight amount of pus in the canal from which no culture was made as the swab was lost. Shrapnell's membrane red. Did a paracentesis under chloroform but got only blood. Under the chloroform her pulse became very weak and it was necessary to give strychnine injections (hypodermic) and oxygen inhalations with normal salt under the breasts. She had a peculiar eruption over the abdomen and complained of intense pain in the back of the neck, lumbar and frontal regions. Symptoms now all pointed to meningitis. On the morning of the 9th a lumbar puncture was made showing almost pure culture of the pneumococcus, leucocytosis of 35000. In the afternoon her right pupil became dilated. Death occurred at 7:30 p.m. Patient retained consciousness almost to the last.

Autopsy.—On removing the skull cap the right hemisphere was found bathed in pus which had traveled down the right optic nerve. On inspection the right petrous portion of the temporal bone appeared to be normal but on a slight tapping with the chisel the whole bone caved in, being entirely necrotic filled with pus and granulation tissue. The mastoid was not opened, the autopsy being performed by a novice who, in his carelessness, destroyed the petrous portion of the temporal bone thus losing much valuable information.

This patient had had no pain in her right ear until four days before her death. If the temporal bone had become infected on the day the pain in the ear began, was there time enough for the petrous portion to become entirely necrotic? Was there not rather primary osteomyelitis here with secondary involvement of the middle ear?

CASE III.—The last case is reported in detail as it presents some very interesting symptoms, which in a great measure deceived the physicians who were called in on the case.

I was called on the morning of January 11th, 1905, to see F. M., age 15, who was suffering from acute pain in the left ear which had started about two o'clock that morning, lasting until five, when the ear began to discharge some serum.

When examined at eight o'clock I found intense congestion of the drum, with bulging, a small pin point perforation at the middle of the drum, which seemed to be blocked with secretion. Under chloroform anesthesia the left drum was opened freely evacuating large quantities of bloody serum. The patient at once went to sleep and slept the rest of the day in perfect comfort, the ear discharging well.

The following ear history was obtained. He had had frequent attacks of ear ache, the last attack being about Thanksgiving, when his right ear ached for some little time and then discharged pus for a few days. At this time his ear was treated by syringing but not under the care of a specialist.

Before incising the left drum the right was examined and some congestion of Shrapnell's membrane found. Also a slight ring of congestion extending nearly the entire circumference of the drum. He had no pain whatever in this ear but his mother was advised to apply a hot water bag to it, which she forgot to do as he was so comfortable. At 5 p.m. the boy's temperature was 103.3, pulse 116. Right drum was not

as much congested as in the morning. The left ear was discharging freely and was perfectly comfortable. On calling the next morning I found that during the night the right drum had ruptured without any pain or warning, discharging yellowish pus with some odor. The left was comfortable and draining nicely. Temperature 100. The patient was given calomel purging, and bi-chloride douching for each ear. At six p.m. I learned that his temperature had been high all day reaching 104 several times. He was free from pain, both ears discharging copiously with slight tenderness of the mastoid on the right side. January 13th temperature at 8 a.m. 101, ears discharging freely during the night but both throbbed with sensation of dull pain that morning. I syringed ears with bi-chloride solution getting away considerable secretion with relief from pain and throbbing. Temperature reached 104, pulse in the neighborhood of 100. January 14th his temperature kept high all day, but his ears were comfortable and discharged freely. Politzer inflation was used with good results. From this time on his ear symptoms gradually improved, the discharge grew less daily and ceased by the 25th.

On the 14th a consultation was held with Doctors King, Black, and Sherk, to if possible, discover the cause of the high temperature, but nothing was found. The boy felt perfectly well, his only complaint being that we did not allow him enough to eat, and he continually expressed a desire for beef-steak. He was unable to sleep much after the first day of his illness. January 15th he seemed to be better, but his temperature ranged from 102.5 at 6 a.m. to 104 by axilla at 4 p.m. and at 8 p.m. was 102. January 16th, aside from his temperature he was much better. The range was from 101.3 to 103.4. January 17th—highest temperature was 103.2, lowest 101.8. On the morning of the 18th his temperature

was 100.8, but by 4 p.m. had reached 103.6.

Dr. J. M. McBride saw him in consultation but could not account for the fever and gave a very hopeful prognosis.

January 19th, his temperature reached 104.5 at noon and a bath brought it down to 101.8, but it immediately began to go up and at 8 p.m. was 104.6. At that time Dr. Hill Hastings was called in consultation to see if he thought there could be any ear complication to account for the temperature. He found the ears in good condition and apparently not accountable for the febrile condition. He, however, found some fibrillary twitching of the fibres of the pectoralis major muscles on drawing the finger nail quickly across the muscle; there was also a marked Koernig. The pupils were even and active and there were no mental disturbances of any kind. He made a diagnosis of meningitis, not of otitic origin, but probably due to an influenza infection. His prognosis was unfavorable.

Those of us who had seen the boy right along could not bring ourselves to fully agree with him in spite of the evidence of meningeal irritation. We were inclined to view these meningeal symptoms as a result of the febrile condition and not the cause. On the 20th he was about the same. Frequent baths kept the temperature under 103.5 most of the time. January 21st he was not so well. Dr. Sherk did a lumbar puncture but failed to get fluid. His temperature reached 105 and then on Dr. McBride's advice small doses of acet-anilid were used and his temperature stayed at 104. His pulse all of this time was about 100. January 22nd—On the morning of this day he complained first of some lumbar pain, due to the puncture of the day before. At noon there was noticed occasional twitching of the body and that afternoon he spoke of pain in the back of



his head. That night he also complained of headache.

January 23rd.—Early in the morning he had a nosebleed. Later he refused nourishment. He could not sleep but was not in pain. Later in the morning he spoke of pain first in the top of his head, then, in a few hours, all over head, and also in the lumbar region. Symptoms of meningitis were becoming more prominent, but his pupils were normal and he kept pretty rational. That afternoon he awakened from a sleep in sort of a night terror and it took some time to quiet him down. On the morning of January 24th there was frequent jerking of the legs and constant fumbling with the hands. He had a comfortable night, was free from pain, complained some of his back when he moved and was quite irritable when disturbed. That evening there was pain in his back extending downward from waist line and turning caused pain in his neck. Later that night he became irrational at intervals. January 25th I reopened both drums under chloroform, with negative results. He gradually became more restless, would pick at the bed clothes and mutter when asleep, and became more and more irritable when awake. January

26th.—His neck was stiff and would hurt him on turning. There was a profuse serous discharge from the left ear in the morning. January 27th.—He was rational when awake, but very restless when asleep. Once in the afternoon there was considerable serous discharge from his left ear but from that time on was very scanty. January 28th.—He was restless during the morning. At 2 p.m. he said he was very thirsty. He sat up to take a drink of water, and after drinking said, "Why, I can't see," and fell back on his pillow unconscious. Active delirium then set in, his abdomen became distended, he voided urine involuntarily and at 2:10 on the morning of January 29th he died.

Autopsy that afternoon by Dr. Stanley P. Black and myself revealed a rather diffuse leptomeningitis, most marked at the base. There was no necrosis of either temporal bone. Both mastoids were normal. The left middle ear contained a slight amount of serum. There were no evidences whatever found to lead us to think that the meningitis was of otitic origin. Cultures taken from the cerebro-spinal fluid showed the streptococcus. Pasadena, Cal.

## CANCER.\*

### RECENT DEVELOPMENTS IN THEORIES CONCERNING THIS DISEASE.

BY W. B. POWER, M. D., REDLANDS, CAL.

It is an established law in cytology and embryology that the number of chromosomes in somatic or body cells in a given species of animal is always constant, except in the germinal tissue. of testis and ovary, where the number of chromosomes is reduced one half. Thus the number of chromosomes in human somatic cells is 16, in germinal cells 8. The union of the germ nuclei derived from the parents in sexual re-

production gives rise to a nucleus containing the typical number of chromosomes for the given species.

Mitoses varying greatly from the usual type are found in the germinal cells of the testicles and ovary and in the embryonal tissue of the foetus. Such mitoses resemble those normal in many of the lower orders of animals and plants, and are regarded as remnants of an ancestral type. It has recently

\*Read before the Thirty-sixth Semi-Annual Meeting of the Southern California Medical Society at Arrowhead Hot Springs, Cal., May 2, 1906.

been shown that many of them develop also in cancer cells.

In *ascaris* and other nematodes the normal number of chromosomes is as low as 8, 4 or 2. In carcinoma a similar reduction to 5 or 4 has been noted. It is noted also that parthenogenesis, that is, reproduction of germinal tissues without fertilization by the male, occurs in the ova of lower animals, in consequence of chemical stimuli, where the nucleus contains a reduced number of chromosomes.

An increase in the number of chromosomes is also noted in cancer. In sharks the normal number is 36, in certain gastropods 32, and in one crustacean 168.

Multipolar mitoses, having more than two centrosomes and planes of cleavage are also met with in cancer. These forms are not normal to any animal, but are found in the pollen mother cells of plants.

In the mitoses of one species of *ascaris* there occurs a segregation of the chromatin in one daughter cell, which always becomes a germinal cell. The other daughter cell contains no chromatin and becomes a somatic cell. Similar mitoses are noted in cancer.

Amitosis or direct division is found in cancer. This is of extreme rarity in normal tissues that are developing rapidly. It is frequent in the cells of the vertebrate decidua, the embryonic envelopes of insects, or the yolk-nuclei, which are on the way toward degeneration. Amitosis represents therefore either a degeneration or an aberration. Strasburger and Waldeyer conceive it as a survival of a primitive process of cell division from the protozoa. (Wilson). Cancer cell mitoses in which the chromosomes are fed, bunched, and attached to the long axis of the spindle, and divide transversely, are also noted normally in some fishes.

Cancer and benign tumors are prone to start in those tissues whose cells

are least differentiated and more nearly resemble ancestral types, such as one-layered epithelia and connective tissues. These have naturally great power of proliferation. Regeneration of highly differentiated tissue, as nerve cells, after injury is not observed, and tumors containing nerve cells are of the rarest.

Germinal cells contain the potentiality of becoming either epithelial or connective tissue. A case of "adeno-cysto-sarcoma" is reported by Bushnell and Cavers in which the columnar cells of the intra-cystic growths were seen passing by gradual transition into large sarcomatous elements. In a similar case of Grunbaum's sarcoma cells were observed in transition to cells resembling columnar epithelium. This was not considered a transformation of one tissue of adult type into another, but a case of two types of cell having a common ancestor in the germinal cell in which the growth started. True mixed tumors are reported in the literature as forming metastases containing both cell elements.

Beard, whose researches in the field of cancer are noted, reports having observed belated germinal cells in developing fish. These took on somatic characters and acquired the requisite number of chromosomes at the time of the development of the pancreas. On this fact he builds the theory that trypsin is the enzyme concerned in the disappearance of the germ cells. He reports the successful use of trypsin in cancer of mice, but the publication of this claim is premature, and judgment must be suspended.

It is a matter of common observation that embryonal and germinal structures persisting in adult life frequently become cancerous. Particularly is this the case in the so-called chorion-epithelioma occurring after abortion, malignant moles, proliferating ovarian cysts and dermoids. Schaper and Cohen localize the proliferative cell material

from which tumors are formed in the so-called "growth centers." These are tracts of undifferentiated cells where embryonal mitosis persists longest, such as the layer of osteoblasts on the inner surface of the periosteum, the palisade cells of the Malpighian layer of the skin, the deeper portions of Lieberkuhn's follicles and uterine glands, the ependymal wedges of the cerebro-spinal neuroglia. Tumors certainly seem to begin in these structures frequently, so far as we can judge by the limited means of observation at our command.

Once established, the cancer cells become practically a colony of unicellular parasites. Their rate of multiplication unrestrained by any law or allegiance to the body or each other, they invade the organism as long as nutriment is supplied to them. Akin to the normal tissues, though living at their expense, they do not in forming their outpost colonies, excite phagocytosis until by their multiplication they act as a foreign body, or by their degeneration form irritative poisons. How different is this from the immediate reaction of the tissues to the bacilli of tubercle, or leprosy, of anthrax or of glanders.

If we grant, as I think we may, that germs called aberrant in the body may develop into either epithelial or connective tumors, it is unnecessary to consider the occurrence of heterologous tumors as contradictory to Cohnheim's hypothesis. Indeed, the occurrence of chondroma of the parotid, long used as an argument against this theory, has really been an endorsement thereof, as cartilage cells have been frequently demonstrated in normal parotids. The cancers sometimes arising in old scar tissue form the strongest argument against the theory. It is alleged by the supporters of the theory that in such scars germ-cells are stimulated to action by irritation as they lie in the adjacent tissues, or that epithelial implantation takes place by traumatism,

or that the germ cells drift into the tissue by the blood-current or lymph-channels, or by amoeboid movements, from the edges of the old wound. In spite of this apparent obstacle the recent advances in cytology endorse, as a whole, Cohnheim's hypothesis.

The problem now before us is—Granted the presence in the tissues of cells of embryonal type, what are the conditions or factors that cause them to take on increased growth? Trauma, chronic irritation, and the modifications of normal growth seen in the degeneration or involution of such structures as the breast, uterus and skin in the aged, all have their undoubted effect. It is well to recognize clearly that a parasitic theory, or a metabolic one, are not in the least incompatible with the theory of belated embryonic cells. All the polemics indulged in by writers on this subject may after all turn out to be only a repetition of the old story of the two sides of the shield. Because most benign and some malignant tumors arise without parasitic contamination it does not follow that such contamination may not be causative in other tumors. Nor are the lines dividing benign from malignant tumors sharply drawn. Metastasis in connection with typical chondromata and thyroid tumors has been observed and found at autopsy to have caused death. On the other hand benign neoplasms having the typical structure of malignant growths have been reported again and again. Instances are the benign cystic epitheliomata occurring in the aged, as described by Hartzell in 1904. I was present recently at an autopsy where, death having ensued from other causes, a small spindle-celled sarcoma was found beside the left kidney. The patient was about 60 years of age, and the tumor, of the size of a lemon, and of great density, had never caused any symptoms.

Of great interest in connection with



the cytology of cancer is the production of heterotypic mitoses in the epithelial cells of the salamander under the influence of certain drugs, as quinine.

Hemmeter, while studying gastric cancer, produced artificially gastric ulcer in dogs, and then injected the edges of the ulcers with a suspension of cells from a case of gastric adeno-carcinoma from another dog. This produced a growth resembling adeno-carcinoma. He then injected another series of ulcers with a sterile cell-free extract of the primary growth; this produced similar appearances at the edges of the ulcer. Hemmeter regards this effect as due to an enzyme, as heating the filtrate to 80 centigrade destroyed the effect.

Monsarrat isolated from carcinomatous mammae an organism which when injected into animals caused nodules of proliferation at the point of inoculation and in the internal organs; these were not however, true cancer. About the same is claimed by Schmidt for a protozoan found in certain moulds inhabiting cancer. He claims that the moulds formed the intermediary hosts of the organism. Schmidt elaborated a serum which seemed to cause softening and loosening of the fibrous attachments or cancer of the breast, and inflammatory changes in infected lymph glands. D'Arcy Power of London reports that this serum does nothing more than cause inflammation of any pathologic tissue, whether cancerous or microbic. It is well known that the toxins of erysipelas also cause a change in the growth of sarcomata; the same is true of adrenalin in cancer of mice. The X-ray has a similar effect, causing hemorrhages, shrinkage and fibrosis. It is accused of causing metastasis in dormant neoplasms.

Parasites, either bacteria, protozoa, yeasts or moulds, have also been assigned a causative role in cancer by Nepveu, Rappin, Scheuerlen, Francke, Schill, Ruffer, Schueller, Gaylord, von Leyden,

Feinberg, Russel, Metchnikoff and Doyen. Many of the organisms described are now considered artefacts or cell inclusions. None of the organisms described so far obey Koch's law. Neither bacterium, yeast nor psorosperm has up to the present time been satisfactorily shown to be in any sort of causative relationship to any of the cancerous diseases, in spite of years of patient study by many skilled workers.

The increased frequency of cancer is often cited in support of the parasitic theory. Probably everybody notes that he hears of or sees a greater number of cases of this disease than formerly. Some of the apparent increase may be due to better diagnosis, as was the case with appendicitis. The registrar-general of France states that there has been no increase. The statistics taken around Stuttgart show an increase, also that the cases are more frequent in portions of the town near a certain stagnant ditch than elsewhere. Researches carried on in Buffalo under the auspices of the State Pathological Institute point to an uneven distribution. The cases also follow a water-course, the possible water-borne, and that infection takes place through the eating of uncooked vegetables, etc., which have been rinsed therein. "Cancer houses" are also de-  
 ity suggesting itself that the disease is scribed, wherein unrelated persons have fallen victims. The influence of heredity is familiar and striking. The progenitors of Napoleon the First were particularly liable to cancer of the stomach, to which disease the dictator himself succumbed. Cancer is rare or unknown in high latitudes, as Northern Greenland. Among savages it is rare. Cancer in England seems least prevalent in limestone regions, most prevalent in badly drained clays. In India the vegetarian Hindoos are more affected than the flesh-eating Mohammedans. On the other hand, the Jews, whose diet differs little from our own,

are very prone to cancer. Statistics regarding the effect of race, diet, soils, etc., are of less value as arguments for a parasitic theory than at first sight appears. An analogous case is the prevalence of goitre in certain valleys in Switzerland, yet a parasitic origin has never, to my knowledge, been claimed for goitre.

Transplanting of cancers from one part of the body to another, accidentally, as in the case of infection of the upper lip from the lower, or experimentally, proves nothing more than successful epithelial grafting. Of greater significance are the occurrence of epidemics of cancer among rats, and the cases cited where healthy mice confined among cancerous ones developed the disease. Cancer has never been transplanted from one species to another. This is in accord with the well-known law of the specificity of cells. It is interesting to note that cartilage and thyroid tissue, both of which when in benign tumors may form metastases, survive longest when implanted in an alien species.

Chronic irritation is a strong etiological factor in both malignant and benign tumors, but it proves nothing for or against the parasitic theory.

Implantation of epithelium into deeper connective tissues may sometimes have an effect in producing recurrences after operation. It is well, in operations on skin cancers, to manage our incisions and sutures so that no epithelial cells shall be drawn into the corium, and that no glands shall have their ducts occluded by the new scar.

Thiersch's theory, that cancer is due to a loss of nutritional balance between the epithelial and connective tissue elements of the body, though advocated by men of great ability, has not lately been brought much before the attention of the profession. The same may be said for the theory that cancer originates as

a trophic disease of the nervous system.

TO RECAPITULATE—The weight of evidence at present is in favor of the theory that cancer is a tissue-vice wherein the cells revert to embryonal or ancestral type, with the intense vitality and capability of reproduction characteristic of such types, and lacking the restraint of allegiance to the law of the general organism.

That the cause of this reversion is either a poison developed by a parasite, or an enzyme originating in the cell itself.

That there is only a slight probability that parasites cause any of the varieties of cancer.

That if cancer is caused by a parasite, every form of the disease, within reasonable limits, must be caused by a separate organism, and every species of animal must have a separate variety of organism for the same class of cancer.

That we are almost entirely in the dark as to the vital properties of the cell, the laws governing its reproduction, and the nature of the enzymes contained therein.

That the cause of cancer is to be sought in the fields of embryology and cytology, not of man alone, but extending over the whole of the animal and vegetable world. It is only by a broad outlook that we can gain any clear conclusion concerning a disease so various and so protean.

In conclusion, there seems just at present a ray of hope in some of the experiments in the organolytic sera. We are now able to elaborate a serum that is capable of destroying in animals the liver alone, another the kidney, another the testis. In man the principle has been applied to the destruction of the thyroid gland in exophthalmic goitre. Considering the infancy of the subject it may not be too much to hope that this principle of the development of sera antagonistic to special tissues

will be successfully applied to carcinoma and sarcoma. Meanwhile, we should insist on the early and complete removal of all suspicious growths.

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## DISCUSSION OF DR. POWER'S PAPER.

DR. WOODS HUTCHINSON, Arrowhead Hot Springs:—In the absence of Dr. Stanley Black, he had been asked to open the discussion. The paper dealt with a most important problem, for cancer is a disease that is on the increase. Fortunately, it does not attack the individual until his reproductive capacity is over. The parasitic theory was not in high favor, although for a time about once in every ninety days, an investigator would announce a new germ—which later on would

be found to be nothing more, perhaps, than air bubbles. His distinguished relation, if the allusion were pardonable, had referred to the cancer process as a rebellion of some of the cells. Murray and Bashford of the English Cancer Commission had referred to cancer cells as being sexual cells. Time, no doubt, would add much to our present knowledge of the subject.

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DR. GEORGE W. LASHER, Los Angeles:—In a conversation with Dr. Welsh about two years ago, Dr. W. stated that the pathological world was still in profound doubt about the entire subject. Dr. L. was satisfied that the disease was increasing, although some contended the larger number of cases was due to a better diagnosis. In his early practice in the lowlands of Illinois, he recalled several houses called "cancer houses," where a number of members of the same family had died of the disease. Was the etiological combination one of a parasite, a slight injury and a locus minoris resistentiae?

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DR. ALBERT SOILAND, Los Angeles:—Recalled a case of metastasis through treatment with the X-Ray. X-Ray operators make no claim of efficacy in internal cancer from Roentgen ray therapy. But on skin cancers, the X-Ray has a specific and selective action.

\* \* \*

DR. W. W. HITCHCOCK, Los Angeles:—In removing uterus because of carcinoma, he had frequently adopted plan of exposing wound before closure to the X-Rays, and had seen no recurrence. It was important also not to allow cancerous tissue to come in contact with healthy tissue during excision.

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DR. O. O. WITHERBEE, Los Angeles:—The locality of the carcinoma had considerable to do with the liability to recurrence.

## THE SUBSTANCE AND THE SHADOW IN MEDICINE.

## THE UNDERLYING PRINCIPLES OF THE PRACTICE OF MEDICINE—ITS RELATIONS TO THE OTHER LEARNED PROFESSIONS, AND WITHIN, TO ISMS AND PATHIES.

BY W. B. SAWYER, A. M., M. D., RIVERSIDE, CAL.

There is a German story of a man who sold to Satan his shadow, but no sooner was the bargain completed than his life became a burden. The subject of ridicule, everywhere tormented and laughed at, he was finally driven to seclusion by the street boys, who pelted him with mud and cried, "Respectable people always carry their shadows with them."

## SHADOWS NATURAL TO ALL THINGS.

Respectable people and respectable professions alike have their shadows. A necessary accompaniment and an outward evidence of every substantial thing is its unsubstantial semblance. The pro-

fession of medicine casts many shadows, and to discriminate let us first inquire for the substance in the genuine physician which is wanting in his shadow, the quack.

## THE TRUE AIM OF MEDICINE.

Through all times since "Man's first disobedience," and "the fruit of that forbidden tree" brought death into the world, and all our woe, what we now call the science of medicine had been seeking the means of knowing our bodily ailments and alleviating our infirmities. At first slowly but with ever increasing progress as the various branches of in-



vestigation acquired greater facilities and more generally admitted facts, even to our day it has been the object of the profession inductively "to group together in wide-reaching generalization what facts have been attained, and put these facts thus grouped in a form as a general law." It has sought to gain its general laws, its universal form a sum of the particulars. Were it possible in this search to attain all the facts to complete the circle of the universal by the entire sum of all the particulars, then it would be a perfect inductive science, and from the absolute laws thus attained absolute conclusions might be drawn and the principles for an art laid down without the possibility of error. In every case there would be but one course to pursue and each practitioner like his fellow with definite precision and absolute accuracy must follow this course to its end, whatever it might be.

But our science never can thus attain all the facts. Follow out to their most far-reaching point the investigations in Physiology, Pathology, Bacteriology, Pharmacology or Chemistry, and that point only represents a headland reaching out into an as yet unexplored sea, every sound in which should be taken and every current noted before a chart can be constructed by which the practitioner may safely and certainly shape his course. There are comparatively but few facts in all these branches about which today there is not an honest difference of opinion between men equally close observers, and accurate reasoners, and though to their honor and credit be it said, experimenters are daily increasing the range of knowledge and opening new avenues for the attainment of facts, the science inductively is but a very imperfect one. But there is more in the science than would appear if viewed merely in this aspect. There are many general principles certain and universally recognized from which those for the art may be inferred. The general

laws of health and wider principles of nature are in every case more or less widely applicable, and aside from these there are some certain laws of disease as well as health, of abnormal as well as normal nature, from which may be deduced rational conclusions for treatment. So far I have alluded to medicine only as a science, but it is more than this. It is also an art. "Science affirms principles, no matter whether inductively collected or deductively reasoned out, and "art puts them in practice." Now correct and honest art will put in practice only such principles as have been experimentally proven correct, or correctly deduced from uncontrovertible laws, and in this lies the essence of the true physician.

#### THE VERITABLE DOCTOR.

The veritable doctor ("learned one") is that one who is too wise to be misled in the region of experimental research or reason from unfounded or ill-founded principles, and too honest to deceive as to the value of such research, or profess to believe principles he knows to be false or questionable. He values at its just estimate what and how much of benefit science receives from inductive methods, and will endeavor to the full to add to their results. He adds to the facts gained by experiment such laws as sound reasoning from known and undisputed principles has given him or his predecessors, and he brings these into the practice of his art, and none but these.

#### THE QUACK.

In this, then, as in all things we are pointed toward two grand characteristics in the individual which give him that substantial entity without which he is and must be a quack, and these two are wisdom and honesty. The man must have them both or he can no longer cast a shadow, he may discard either or both, and still be a very respectable one. The descriptions and definitions of the quack variously given bear out this view. In the charter of one of the oldest med-

ical societies I find it said, "that a just discrimination should be made between such as are duly educated and properly qualified for the duties of their profession, and those who may ignorantly and wickedly administer medicine." A good and wise physician of many years' experience writes, "A regular physician is one who devotes himself to the acquisition of medical science and art, and their application to the treatment of the sick; the charlatan or quack ignorantly administers medicine for selfish ends." Still another says, "when we speak of a quack in medicine we commonly mean one who knows that he is deceiving the public by pretending to have knowledge and skill which do not belong to him," and the name of quack itself, i. e., "the boaster." These are all descriptions of this professional semblance, and may be comprised in the simple definition, namely, the quack is he who without wisdom or honesty, or both, professes the science or attempts to practice the art of medicine. This definition covers the whole race. There can be and there are ignorant quacks, and well-educated quacks, honest and dishonest ones. There are quacks who, placing too implicit confidence in the results of inductive generalizing, promise for the science more than it can accomplish, and with an innocent simplicity, more deserving of pity than contempt, claim results for the art more far reaching and certain than its most zealous defenders. There are quacks who from general principles they either ignorantly believe to be true, or dishonestly know to be false, deduce laws for the art which followed, lead only to the lame and impotent conclusions of shameless nonsense. Every one in the almost endless variety of charlatans comes under one of these two heads, which are the Scylla and Charybdis between which every true physician must steer. To put in practice all that is known nor yet to claim

as results or promise as effects of the means used more than the science will warrant, are imperative duties laid on the shoulders of those who would hold intact the substantial elements of true medicine, and a failure in either respect ought to and does brand the practitioner—a Quack.

#### THE CAUSES OF QUACKERY.

Ignorance and dishonesty I have tried to show are the distinguishing characteristics of quacks as individuals, and in a wider application to society they are the causes of the evil itself. Ever since the sons of Aesculapius treated their patients by solemn rites and incantations in the temples of the Gods, even to the present, when the simplest prescriptions are clothed in the garb of a dead language, our profession has been invested with an air of mystery. The physician has been named doctor, i. e., the learned one, and regarded as the man to whom nature and science have revealed secrets unknown to others, by the means of which he might control disease and alleviate suffering, and more than this. Forgetting that all men are mortal and finite, and subject to the same immutable laws of nature, to the practitioners of medicine, the community have ascribed attributes they cannot possess. They have been looked upon as having the power to thwart and overcome nature. The language of the day bears evidence of this common and widespread error. "Such and such a doctor," says one, "cured me." In a well-known medical journal even I find it said that "it is a disgrace that no cure has been found," for some ailment, here implying, as all the world does when it goes to its family physician to be "cured," that to him and the medicine he uses is to be ascribed the return to health—a victory over disease—and that he has circumvented the usual course of nature.

And this species of ignorance runs through all classes of society, finds expression in the press, in the pulpit,

and the language of common parlance, and is one of the radical causes of quackery. For so long as the community believes that medicine cures disease, and that medical men by its application overcome natural laws, it will believe that a return to health from any ailment has been the result of such medication, and will justly and honestly praise and be grateful for it, whether it be some rank concoction of a street fakir, or the correct dose of an official drug.

The term specifics as applied to medicine is a bad one, for there are few if any specifics in the meaning of the term as loosely applied by the public, i. e., certain curative agents for certain diseases. In an absolutely harmful way, too, the popular belief that many acute diseases may be "broken up" at the start, and that if broken up too soon the disease will be sent somewhere else, and "the devil to pay generally," and a thousand and one similar erroneous ideas attest how little the community at large appreciates the true principles of medical art. That all disease to a greater or less degree is self-limited, and that there are no such things as specifics are certainly facts widely misunderstood. Is it not also true that in many cases with a carelessness bordering on dishonesty, good and reputable physicians allow their patients to remain in ignorance respecting these facts, and thus aid indirectly in the practice of their pseudo-brethren?

#### THE ATTITUDE OF THE PRESS.

In the public press, in the pulpit, and in the law also, may be found prevailing the same unfortunate misconceptions and their expression. The press, aside from its paid advertisements of all sorts of nostrums, nostrum vendors or graceless charlatans, gives ready credence and wide circulation to all sorts of editorial foolcisms. Regarding itself as the educator of the masses, it does not neglect the chair of medicine, but gives free lectures without, however, any preparation by even sip-

ping at the fountain of knowledge in this branch. That one who would not attempt to criticize even the methods of the engineer, who would hesitate to question the established rules of arithmetic, or does not even doubt the facts of navigation, should still deem himself fully capable of expurgating the entire foundation principles of medical science and call in question the very existence of any and everything pertaining to the established order of things in this most scholarly and classic profession known, is as ridiculous as it is true, and aside from its painful ignorance and laughable assumption of wisdom the press in many cases is as dishonestly venal in regard to affairs of legislative influence in a medical line, as it is when the greed of the professional grafter or boodling politician buys it for his individual ends.

#### THE ATTITUDE OF THE CLERGY.

The clergy whose years of study have developed their understanding of faith until it is often made to supersede reason, are very ready to give their support to any new ism, if it only requires them to believe and they shall be saved.

#### THE ATTITUDE OF THE LEGAL PROFESSION.

Lawyers in many cases also show an absolute ignorance of the true character and position of the physician, and will quote as strong argument in some legal proceeding, the words of an arrant quack in the same breath and with the same emphasis as those of a worthy and well-credited man.

#### THE SO-CALLED OLD SCHOOL HAS NO DOGMA.

The variety of quacks is almost unnumbered, their name legion, and though they are all well known to the profession, it may not be uninteresting to see how well the suit of ignorance and dishonesty may fit some of them. Of all the professions, none is broader in its views, more catholic in its spirit, more eager to accept every advance, and every proven advantage than the profession of medicine.

Permission is freely granted each individual practitioner to hold for him-



self any reasonable theory, and to practice his art in such accord so long as it shall be based on the known, the proven and the true facts of the underlying branches of the science. A tenable reason for the faith that is in him in accord with the well-recognized laws of all science covers the ground for every act, but to no one can be permitted in the nature of things the narrow, inelastic hard and fast bounds of any dogma or pathy. The claim of a dogma is dishonest, since there is none, not accepted or rejected, which can be placed in universal use. Everything in medicine must be unanimously accepted, and no facts can be half believed or partly right and partly wrong. There can be no pathy practitioners, the medical man is either a doctor or a quack. Any school, ism, dogma, cult or pathy in medicine about which or its theory or practice there is an expressed doubt (and there is such about them all), is on the same plane medically as is socially the damsel whose chastity is lightly questioned. The times demand the doctor, and not the upholder of a creed, and the acceptance of any ism shuts the door and leaves outside among the shadows every man who would enter the halls of medicine. Allopathy or the other term, en-auto-pathy, homeopathy, hydropathy, neuropathy, naturopathy, osteopathy, anything-o-pathy, have no right to pass as medicine. They may each possess and use some method, some line of reasoning, or some valuable adaptation of medical laws to the practice of the art, but the same is always to be found (without the lack of other means, methods and adaptations that the narrow path bespeaks) in the armamentarium of the legitimate, and the real. The pathys are shadows, deriving only their form and superficial value from the substantialities, they borrow from the wide and all-embracing profession whose similitude they try to bear.

#### REGULAR PRACTITIONERS ARE NOT ALLOPATHS.

The old theory that disease was a humor or poison seated in the system, which gave rise to different symptoms and manifestations, and which was to be driven out by purges, blisters, clippers and bleedings, went hand in hand, and was contemporaneous with the theological myth of the personal devil, whose exorcism was in similar manner necessary before the soul could hope for heaven. No one at this day among any of the practitioners of medicine who lay claim to regularity will admit or allow others to suggest that he is an allopath. The term was erroneous in its first conception and derived its meaning from an untenable theory that the evil humors of disease were driven out by material substances, their opposite in effect from the various organs and subtle processes of the body. The advanced steps in physiological and pathological knowledge based on the disclosures of the microscope and the exact results of chemical research, have placed the profession above and beyond the pale of such bungling theory and nomenclature.

#### HOMEOPATHY.

Equally abhorrent and more viciously obnoxious to the true spirit of medicine were the so-called homeopaths. The name invented originally for a theory equally as untrue and contrary to scientific fact as the older term, was used as a cover not only for the treatment of disease, diametrically opposite to that of the so-named allopaths, but for a wide range of ridiculous and unscientific postulates and wild theories in regard to pharmacology which its defenders pretended to and perhaps did believe were discoveries, but which were the boldest travesties on science. Hahneman, the founder of this sect, announced certain theories and deduced principles for an art, and his followers either conscientiously adhered to them or not. If not, it requires no argument to show that they were using the name commercially to draw trade, and not

scientifically to prove a theory or cure disease. Such as did adhere to them were equally in the category of bad medicine. The foundations gained by their inductive methods can not bear the slightest comparison either in number, correctness of detail or exactness in individual instances with the wide range of experimental knowledge gained and handed down for centuries by the professors of the legitimate art. Yet if they were as full, correct and well accredited they could not furnish a basis for a system of therapeutics consisting as these did, largely of specifics. For the experiments must be taken as absolutely without error, as having surrounded every possible contingency and grasped the entire universal, or they will not serve as rules for absolute treatment. But the real fact is that the alleged experiments were few in number, stupidly and inaccurately conducted, neither carefully reported nor tabulated, and showing results so ridiculous on the part of them that a man of ordinary common sense can but laugh. That an infinitesimal portion of a grain of common salt taken into the stomach would produce symptoms in all parts of the body and induce mental phenomena as well, and that the more infinitesimal the portion the more pronounced the symptoms to be proven, would require a number of experiments as great as the amount of chemical is small, and a mind in the experimenter equally infinite and equally diluted with the inert water of credulity. And deductively reasoning from the theory that like cures like, twist it as they would, they started from a premise that is neither universally recognized as true nor admitted universally as correctly proven, and hence logically they might not infer from it any principles for the science or carry them into the practice of the art. There are really today no homeopaths, just as there are no allopaths among good medical men. The day and age for such

discriminations is past, and no one can be found to explain the reason of their original existence, except on the ground that such schools of practice came as the last effort of superstition against the incessant approach of definite reason and clear science. The sound common sense of the nineteenth century was too much for "Dr. Squills," and the followers of little pills and high potencies alike, and while there are some who stick in their dreams to the old names, and others who allow them to be used in their own individual cases for commercial profit, there are no men at the same time honest and scholarly who follow out the tenets of the old schools. May their shades abide in peace. Among one of its class characteristics, "The Profession" has the habit of doubt. Investigators and practitioners alike demand proofs. Every single fact must be proven and corroborated, tested, tried and verified again before acceptance, and this scientific skepticism is a stay to faulty theorizing and speculative philosophizing. To be genuine is to harbor legitimate doubt, and many an excursion by the profession into the realm of spectral and shadowy practice has been cut off by the careful and conservative doubter.

#### CHRISTIAN SCIENCE.

Another trait in practice and used continually is the recognition by the practitioner of the correlations in his patients of mind and matter, the influence of the one over the other, and the necessity for and use of mental conditions, feelings, hopes, fears and their moral congeners is constantly in view. The patient is placed in comfortable quarters, is surrounded with hopeful and cheerful nurses, is encouraged in the belief that his disease is not dangerous; his favorable symptoms are emphatically dwelt upon, and he is sometimes kept in ignorance of what may be depressing and dark factors in his case. It is well known and practically admitted in treatment that sug-

gestion, the essence of hypnotism, often lessens the appreciation of pain and increases the potency of drugs. Belief in the doctor and the potency of his armamentarium, confidence in what is said and done, etc., these are facts of psycho-therapeutics constantly taken advantage of by medical practitioners in their care of the sick. Picture to your self the shadow of this substantial legitimate scientific group. These proven elementary principles in true medicine, taken in connection with a superficial reading of the Holy Scriptures, backed by a skepticism that denies all material properties and amalgamated into a meaningless and unexplainable hodge-podge of silly and irrational platitudes about Truth and God, and sin, and sickness, and love, produced the medicopsychologic miscarriage known as Christian Science. It is neither good religion nor possible science, and is the shadow only of the substantial facts that you can encourage health better than you can discourage disease, and that confidence in the doctor and in the means he uses increases the efficacy of both, that the majority of diseases are imaginary and hysterical, that the greatest number of diseases tend to get well if left alone, and that many patients need no medicine whatever. I am forced to believe that most of this class of unfortunates are honest, and choose to think that they have so hypnotized themselves as to actually believe that there is a Divine and Supernatural something in their nonsense, but I defy them to so understand it so as to define, or describe it rationally to any finite mind. That most of these people are honest and daft is true, and it is equally true that some are not "harmless as doves," albeit "they are wise as serpents," and dishonest as hell. Any class who uses the truth with as wide and circular a variation of construction as this sect it is hard for one to classify as clearly and purely honest. The Christian Scientists who constantly and persistently

evade the laws of man and make a bold attempt at getting around the laws of God by emphatically asserting that they are not practicing medicine, but who practice medicine, advertise, talk about their cases, and make their living by an equally emphatic asseveration that they are healers, divine healers at that, are unchristian scientists, and unscientific liars.

Persnally the profession stands on too high and holy a plain to mix in useless argument or degrading war with these people, and cares but little how inextricably they may mix up their own aches and truths and pains and loves, but when they stand in the way of treatment needed for the life of helpless children and old people, and prevent those perhaps threatened with death from obtaining succor that is genuine, then medical men have a just right to be indignant.

#### OSTEOPATHY.

The first, the most important and the fundamental study of the medical man is anatomy, and the basis of anatomy is the skeleton. The bones in a general way give the names to the arteries, veins, and nerves, and landmarks of the body, from which again are derived the location of diseases, etc. Constant, almost daily reviewing of anatomy and of the bony skeleton is, I venture, the rule with most medical men. How to diagnose, reduce, replace and retain in place every possible fracture and dislocation are problems on which have been written whole libraries. The manipulation of muscles when sore, or in pain, the correcting of various deformities by the use of the hands alone, have been made special sciences in the scientific whole.

These have also cast their shadows, and we have the osteopath. He is the anatomist gone to seed, and the masseur gone crazy. He shadows the regular in his name, the massage operator in his method, and the hypnotist in bamboozling the public. I have actually known him to diagnose a



dirty nose as a broken neck, a broken leg as a sprain, and to treat a case of fatal diphtheria by rubbing the outside of the neck. These people are, in the nature of things, grafters, pure and simple, and get in their scientific work on the body politic by "pulling its leg."

#### ECLECTICISM.

Then there is a class who write themselves M. D.'s who carry medical and surgical grinsacks, and otherwise pose as physicians, who are known as eclectics. They are equestrians who would bestride two or more horses at once, but they are not like the circus riders, for the latter is careful to select such animals as are going the same direction. The Standard definition of eclectic is "selecting and combining without unity, principle, or a consistent system"—applied that to a doctor and he is both unwise and dishonest.

#### OUT AND OUT QUACKERY.

Then we would include in a single long list a lot of lewd fellows of the baser sort. Cancer doctors, herb doctors, catarrh doctors, doctors for private diseases (publically expressed in public print); humor doctors, tape-worm removers, clairvoyants, natural bone setters, watch repairers, who call themselves eye specialists because the law

does not prevent them from attempting to fit errors of refraction in the eye and sell spectacles, and druggists who prescribe Peruna in the front store and sell something else on prescription only in the rear, and whose vanity is often tickled by the customer's deferential appreciation of the physicians only title. These are all quacks, knowingly ignorant of the qualifications and willfully dishonest in pretending them, and are shadows in that in some way or other they use some counterfeit of the real doctor, or his professional belongings.

#### IN CONCLUSION.

My friends, the shadows lie ever on the ground, the substance points to the heavens, and is crowned with reason. As men whose lives are devoted to the noblest of callings, let us guard as the most precious of our possessions our professional honesty and enlightenment. We must have our shadows, but we may always stand "with clean hands and a pure heart" in honesty, so facing the light of public and private criticism that these shadows shall fall behind us, and in the highest and broadest wisdom so erect that the noonday light of this age of knowledge and thought shall cast them under our feet.

## LABOR.

### REPORT OF A PECULIAR CASE.

BY CHESTER MAGEE, M.D., LOS ANGELES, CAL.

In the spring of 1903 I was engaged to care for Mrs. F. C. whose expected confinement was to take place the following August. Family history unimportant. Personal history: rather anemic woman, aet. 28, height 5 ft. 2 in., weight about 110, primipara, occupation, vocalist. She had had scarlet fever at the age of 4 the sequel of which was a well-marked mitral insufficiency with a loud blowing murmur audible some distance from the chest wall and the entire precordium heaving with each systole. On account of the heart lesion she had hesitated for several years to allow her-

self to become pregnant fearing that the labor would greatly embarrass the heart's action. Compensation however was perfect, her only trouble being palpitation due to gas from an indigestion from which she had suffered more or less for several years. On examination of the urine I found the urea very low in several specimens, so ordered it saved for the 24 hours and the total amount was under 15 grams for that time. 31-40 G. is normal. I concluded that she was not getting sufficient nitrogenous food and ordered those articles added to her food including meat (she being a vegetarian)

which I thought would accomplish the desired result. But in spite of the increased nitrogen intake there was no apparent increase in the excretion and this worried me considerably for a time as such a condition is believed to be a forerunner of trouble. But she was apparently well in every way and as there was no albumen, headache or eye symptoms present, I decided that there was no danger imminent and determined simply to watch her closely.

A short time before the expected confinement the husband came to me and said that his wife was a "mental scientist" and wanted to take treatment before and during the confinement as they had told her that she need not have any pain at the labor with their treatment. I said that I would have no objections providing that I should have full charge of the case as soon as labor began. I was summoned to the case early in the morning of Aug. 12th. Examination showed the child to be in L. O. I. A. position the head engaged. Pelvic measurements were normal. Labor progressed slowly. The pains were infrequent and poor in character, but both mother and child seemed to be in splendid condition.

Patient at this time was receiving absent treatment. That evening the "Absent" became "Present" and it was confidently expected that the labor would terminate speedily. Not so however. Pains became poorer in character as the night wore along and very far apart and finally stopped altogether in the early morning. The cervix being completely dilated I decided that it was useless to wait any longer and telephoned Drs. Bullard to come and assist me. The patient at first refused an anaesthetic absolutely, fearing that her heart would not stand for it. Peristalsis was used till patience ceased to be a virtue when Dr. Bullard with that skill and deftness for which he is so

well noted placed some Ethyl Chloride in a mask and before she could offer any very strenuous objections she was anaesthetized. The head being very high in the pelvis the axis traction forceps were used and were applied or at least apparently applied without any great difficulty, but as soon as traction was made slipped off. A second attempt was made with a similar failure and I then asked Dr. Rose Bullard to try her hand. The result was no better. About this time the child was heard to make a decided cry and I fully expected to deliver a badly asphyxiated if not dead baby. I knew the great importance of a quick delivery if the child was to be saved and again attempted to apply the forceps. As I applied the first blade I noted what I should have in the first place—that the head was very freely movable and that the previous failures were no doubt due to the fact; for while attempting to place the second blade the head would move sufficiently to misplace or entirely disengage the first blade. Accordingly I had Dr. Bullard hold the head firmly from above while I applied the forceps and delivery was easily and quickly accomplished. The child was fortunately none the worse for the prolonged delivery and we proceeded to the repair of the perineum. She had an uneventful convalescence.

Whether or not the "scientist" and her treatment should receive credit for the uterine inertia I am unable to state, but certain it is that her pains were few and far between and poor in character, and I do not think I care to again co-operate with a scientist in a labor case. I am unable to account for the very low nitrogenous output.

400 Grant Building.

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In *tympanites* it is said that one ounce of alum dissolved in half a gallon of water and injected high up results very satisfactorily.

## DEPARTMENT OF DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M. D., EDITOR.

## EDITORIAL COMMENT.

THE NECESSARY REQUIREMENTS FOR INTELLIGENT INFANT FEEDING.—As seen by the table on page 361 of the July, 1906, issue of the *PRACTITIONER*, the percentage of fat, sugar and proteids and the quantity were given up to the 13th month in case that they are needed for so long a period.

If the child has thriven well up to the sixth month on the mother's breast, or until the seventh or eighth month on the percentage feeding, and still is gaining in weight, it is well to continue the breast feeding or modifying the percentage formula as the age advances.

If, however, the child does not gain in weight, or if the gain is slight and unsatisfactory, we may add one or two bottles of modified milk per day to the dietary of the breast-fed infant and this may be continued until the child is weaned, if necessary.

At the seventh month, or about the time of the eruption of the incisor teeth, a cereal is allowed the breast-fed or the bottle-fed infant. This may be a barley pap once or twice a day, or a cracker gruel at the same intervals. If constipated, the barley would better be omitted, but be cautious about the sudden increase of cream to correct this condition, as we have already detailed the evils that may arise from a too high fat percentage.

From the ninth to the twelfth month, in the case of the breast-fed infant, we must consider the manner of weaning.

The caution given in the far Eastern states to refrain from commencing weaning at the onset of summer, does not apply to us in Southern California—practically in Littoral California. Here we may commence weaning without regard to seasons. I rarely see any gastro-intestinal disturbances here that

seem to be seasonal, but I see many due to improper feeding. Nor do we have to wean gradually in order to preserve some breast feeding in case the heat should affect the milk supply or affect the child's digestion. We do not indorse sudden weaning from the breast, but not on account of climatic reasons.

We should allot about eight weeks to complete the weaning. If the baby has had some percentage feeding after the sixth month, the complete weaning is a comparatively simple matter. If, however, the child has been entirely breast-fed up to about the ninth month, the task is more difficult. It will demand some moral courage on the part of the mother, nurse and doctor, and it is often difficult to gain the mother's aid. A breast-fed infant simply will not take the bottle if it can nurse at the breast. We must have the moral courage to deprive the infant at certain times of the day and practically starve it into receiving the bottle. With patience we shall succeed, but it is not a pleasant experience. Some infants will only take enough of the modified milk to barely keep themselves alive and will emaciate to an alarming degree. The problem then becomes difficult as the breast by this time has ceased to functionate. We must exercise tact and patience and the little one will eventually nurse from the bottle. I have never seen a child lose his life from starvation under these circumstances, but the mother will insist that such will be the outcome.

It is well to commence the weaning with a modification of cow's milk that contains from one to one and a half per cent. of proteids and from two to two and one half per cent. of fats.

This percentage is maintained until weaning is completed, then the percentage should be that which is appropriate



to the ninth month, or to the age of the infant if over nine months, and will be seen in the table already referred to.

At this time or a little later, we may cautiously commence the use of whole milk, but it is well to dilute it with water at first in the proportion of 1 to 7. Some infants will take this mixture when they will not take any other. From the ninth to the twelfth month we may add cereals, as barley pap or gralum, rusk or cracker pap twice a day to the dietary of either the breast-fed or bottle-fed baby. For a change, once a day we may give beef juice and barley water in equal portions, salted to taste. Many infants enjoy this and crave more. From the twelfth to the eighteenth month the child's diet becomes more liberal; milk, cereals, eggs and beef juice are now all to be used. The child is fed five times a day, and, as heretofore, milk is the basis of the feedings, but it is accompanied by crackers or other cereals. An egg is given once a day. Fruit juices are very valuable, particularly to a child with a rachitic tendency. We prefer orange juice, but the juice of other fruits may be used. Not more than the juice of a half orange per day should be used.

This is the diet list agreed upon by all of us and found in most of the text books:

**MILK**—Three and a half pints a day.

**CEREAL**—Rusk or crackers, two a day. Light sponge cake, a thin slice. Barley, rice or strained oat meal, once a day.

**EGGS**—One soft boiled, or better, coddled, once a day.

**MEAT**—Beef juice, squeezed from lightly broiled steak and mixed with equal parts of barley water and salted to taste. Two to four ounces a day.

Five meals a day.

From the eighteenth month to the end of the second year, the child is placed on a mixed carbohydrate and nitrogenous diet. This consists of milk, which is still the basis of the diet; eggs,

soups, beef or chicken, vegetables and cereals.

**MILK**—Some take more than three pints others will take very little.

**SOUPS**—Four to five ounces as a portion.

**MEATS**—Boiled meat is the best. May have a lamb chop. Beefsteak, small piece roast beef or chicken. Fat meats and game to be avoided.

**VEGETABLES**—All should be mashed, (those with skins to be strained), and may consist of potatoes, peas, beans, spinach.

**CEREALS**—Barley, rice, triscuit, oatmeal (strained), crackers of all kinds, farina, cocoa.

**FRUITS**—Orange juice, stewed or baked apples, stewed pears.

**AVOID**—Tea, coffee, starchy soups, salads, cabbage, vinegar.

This dietary may be conveniently arranged as follows in the form of printed slips which may be purchased at the book stores and handed to the mothers:

Diet from eighteen months to two and a half years:

Four meals a day:

*First meal, 7 A. M.*

A Breakfast-cupful (f3viii) of new milk; the yolk of a lightly-boiled egg with a little butter and salt; two thin slices of bread and butter.

*Second meal, 11 A. M.*

A teacupful (f3vj) of milk, with a soda-biscuit.

*Third meal, 2 P. M.*

A breakfast-cupful (f3viii) of beef, mutton-, or chicken-broth; a thin slice of stale bread; a saucer of rice-and-milk pudding.

*Fourth meal, 6:30 P. M.*

A breakfast-cupful (f3viii) of milk, with bread and butter.

To alternate with this:

*First meal, 7 A. M.*

Four good tablespoonfuls of well cooked porridge (oatmeal or cracked-wheat), with two tablespoonfuls of cream and a little salt

(no sugar); a teacupful (f3vj) of milk.

*Second meal, 11 A. M.*

A teacupful (f3vj) of milk, with a slice of bread and butter.

*Third meal, 2:00 P. M.*

One tablespoonful of underdone mutton pounded to a paste; bread and butter, or mashed potatoes, moistened with good, plain dish-gravy; a saucer of junket.

*Fourth meal, 6:30 P. M.*

A breakfast-cupful (f3viiij) of milk; a slice of soft milk-toast, or a slice or two of bread and butter.

Diet from two and a half to three and a half years:

Four meals a day:

*First meal, 7:30 A. M.*

One or two tumblerfuls (f3viiij) of milk; a saucer of thoroughly-cooked oatmeal or wheaten grits, and one or two slices of bread (one day old) and butter.

*Second meal, 11 A. M. (if hungry).*

A tumblerful (f3viiij) of milk, or a teacupful (f3vj) of meat-broth, with a biscuit.

*Third meal, 2 P. M.*

A slice of underdone roast beef or mutton, or a bit of roast chicken or turkey, minced as fine as possible; a baked potato thoroughly mashed with a fork and moistened with gravy; a slice or two of bread and butter; a saucer of junket or rice-and-milk pudding.

*Fourth meal, 7 P. M.*

A tumblerful (f3viiij) of milk; one or two slices of bread and butter or of well-moistened milk toast; a baked apple, or stewed prunes or apple.

Diet in childhood:

Three meals daily at table with parents or an attendant, who must see that the food is eaten slowly and is thoroughly masticated.

*Breakfast.*

*Every day.*

Milk.

Porridge and cream.

Bread (stale) and butter.

*One dish only each day.*

Fresh fish.

Eggs, lightly boiled.

“ poached.

“ scrambled.

“ plain omelette.

Chicken hash.

Stewed kidney.

“ liver.

If agreeable.

Before or after this meal one may eat—

Oranges, grapes without pulp (seeds not to be swallowed), peaches, ripe pears, cantaloupes, and strawberries.

*Dinner.*

*Every day.*

Clear soup.

Meat, roasted or broiled and cut into small pieces.

Bread and butter.

*Two dishes each day.*

Potatoes, baked or mashed.

Hominy. Macaroni (plain).

Spinach (purée). Peas.

Stewed celery. Cauliflower. String beans (young).

Green corn (grated).

Junket, rice-and-milk, or other light pudding for dessert.

*Supper.*

*Every day.*

Milk.

Milk-toast or bread and butter.

Stewed fruit, baked apple.

*Drink.* Pure water only. No water with meal.

*Avoid* fried food, highly seasoned or made-up dishes. No condiment but salt to be used.

## REVIEW OF THE LITERATURE.

SHOULDER LUXATIONS IN CHILDHOOD.—A treatment for congenital and acquired luxations of the shoulder-joint is formu-

lated by ROYAL WHITMAN (*Annals of Surg.*, July, 1905). Three cases are described: True congenital, those acquired by violence at birth, and those resulting from injury to the brachial plexus in delivery. The last class is relatively the most frequent. In all cases the first indication is to reduce the deformity. In cases of the third class the ultimate aim is to overcome the inward rotation of the humerus in order that supinations of the forearm may be utilized. The treatment advocated is similar to that of bloodless reduction at the hip-joint. The child, having been anesthetized, is brought to the edge of the table. The shoulder is grasped firmly with one hand and with the other the arm is drawn upward and backward with a pump-handle movement. When the parts become relaxed the head of the bone is levered forward by the thumb. Then abduction is overcome and the head is forced upward. The extremity is then fixed in the overcorrected position by means of plaster bandages, including the thorax. The object of fixation is to allow contraction of the posterior part of the capsule and obliteration of the old articulations; consequently, the part must be fixed at least three months. The after-treatment is of great importance. This consists of daily passive forcible movements to the extreme limits in the directions formerly restricted. When motion becomes fairly free, massage and re-education in function are indicated.—*Medical News*, Vol. CXXXVII, No. XVI, 1905.

\* \* \*

ACUTE DIFFUSE SUPPURATIVE PERITONITIS.—S. J. YOUNG (*Journal A. M. A.*, August 26) has interrogated a number of prominent surgeons as to their opinions as to the propriety of operation in acute diffuse suppurative peritonitis, its contra indications, their methods and experience, and from their answers and his study of the subject, formulates the following general conclusions

as to the surgical treatment of the conditions: (1) Early operations, and it must be remembered that this implies an early diagnosis. Do not wait for shock, which is a symptom of overwhelming infection. Learn to recognize the early symptoms as stated by Murphy: "Pain, nausea and vomiting, localized tenderness, circumscribed flatness on piano percussion, elevation of temperature and hyperleucocytosis in the order named." I repeat it, operate early. (2) Method—Simple incision with simple drainage, placed in the pelvis and in such other fossæ as seem to require drainage. Perforations should be closed, and the appendix removed if it be the offender, provided these things can be done without too much handling of the viscera. (3) Fowler position to retard lymphatic absorption. (4) Physiological salt solution by rectum, one and one-half pints every two to four hours for twenty-four to forty-eight hours. (5) Antistreptococcic serum in suitable cases in hope to combat the effects of toxins absorbed.—*Medical News*, Oct. 14, 1905.

\* \* \*

ACHONDROPLASIA.—Classed under the general head of dwarfism or partial infantilism is a group of diseases which clinically have some points in common and many points of resemblance; pathologically, some of these affections seem to be capable of osteogenetic differentiation. One of them, achondroplasia or chondrodystrophia fetalis, has recently been studied in America by Morse, West, Herrmann and others, and a number of cases have been reported; stimulated by the excellent work done by these authors, Heiman puts on record a case as a possible contribution to the literature of the subject, accompanied by photographs and radiographs.

Summing up the important points in the physical examination, we may say that the noteworthy features are:—

Evidence of deficient mentality.



The broad flat nose with sunken bridge.

The redundancy of the gingival tissues and the high-arched palate.

The short, stumpy limbs with redundancy of the soft tissues.

The disproportion between the length of the trunk and extremities.

The trident deformity of the hands, approximation in length of all the fingers, and malformation of the toes and toe-nails.

The penile hypoplasia.

Retarded growth of the body as evidenced by the weight and height.

The subnormal temperature.

*Archives of Pediatrics*, Nov., 1905.

\* \* \*

ANTI-TOXIN.—*Medicine* for March quotes John Howland (*Archives of Pediatrics*, January, 1906), as earnestly advocating the use of diphtheria antitoxin in far larger doses than are commonly employed. He effectually dispenses of the fear that diphtheria antitoxin has any untoward effects and says the occasional unpleasant symptoms noted after this administration may be disregarded. He approves of the working rule advocated by Holt, that on the second day the dose should be twice that of the first for an equally severe condition, and on the third day three times. It is better to give a sufficient quantity to neutralize the toxin at once than to give it in divided doses. If necessary to give 20,000 units, it would be better to give it at once than to give 5000 units at four hour intervals. The toxin that is unneutralized would remain in the circulation, and inflict irreparable damage. For immunizing a child under two years, except in the very young, 500 units is the proper dose; for a child over two years, including adults, the dose should be 1000 units. A mild, early attack in a child less than two years of age, (those of a few weeks still being excluded) is readily cured by 2500 to 4000 units, but the larger dose

is safer. A similar attack in an older child should be met by the injection of 5000 to 6000 units and when seen late in the disease they should be given proportionately larger doses. When the case is complicated by pneumonia, very large amounts of antitoxin should be given, from 25,000 to 50,000 units. In a considerable number of cases, the Klebs Loeffler bacillus is responsible for the pneumonia, and in such it will be followed by a prompt resolution. Pneumonias, which develop after the antitoxin has been given, which is especially true of laryngeal cases, are due to the streptococcus or pneumococcus, and are not influenced by the antitoxin treatment.

On the other hand Roehr states that the disagreeable results following the use of antitoxin are, susceptibility to another attack of edema, urticaria, and arthritis. By the use of antitoxin, we prevent the system forming its own antitoxin and hence do not gain a permanent immunity. This can be avoided by using the antitoxin in small but repeated doses, enough to check, but not abort the disease. The urticaria, edema, or arthritis may be surely prevented by giving the patient large doses of potassium acetate well diluted, and securing free action of the bowels with low diet. According to the amount of antitoxin used, from 0.3 grams to 2 grams (5 grains to 30 grains) of potassium acetate are given in a glass of water every hour for two to six days or longer. By this method all disagreeable symptoms may be avoided. The action is explained by the remedy favoring elimination which has been overtaxed by the foreign serum.—*Cleveland Medical Journal*, May, 1906.

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SYPHILITIC SYNOVITIS IN CHILDREN.—Many cases are unrecognized, being treated as tuberculous or as subacute rheumatism; and probably many cases of long-standing joint disease that resist treatment are specific. In childhood

syphilitic arthritis may be the result of either the congenital or, rarely, the acquired disease. Sometimes an acute synovitis precedes the eruption in congenital syphilis; again, the synovitis may arise from a gumma in or near the joint. Clinically, however, the joint affections of childhood due to syphilis may be classed as (1) synovitis in infants subsequent to an epiphysitis; and (2) chronic effusion in one or more joints, especially the knees, between eight and fifteen years; in these cases the synovitis is primary.

Syphilitic epiphysitis appears during the first three months of life, and affects chiefly the elbows, wrists, knees and ankles; the arms are more frequently attacked than the legs, and the distal joints rather than the proximal. When not progressing favorably there is separation of the epiphysis, and perhaps further degeneration; then suppuration due to pyogenic infection, and finally rupture into the joint.

The symptoms of true chronic syphilitic synovitis are characteristic. Striking features of the affection are its insidious development, symmetrical distribution, chronic course, freedom from pain and mobility on passive manipulation, its association with other specific stigmata, its amenability to treatment, and its tendency to relapse. Usually occurring between eight and fifteen years, it may appear as early as three and one-half years, and as late as nineteen years. The knees are most frequently involved. There may be neuralgic pains at night, but there is no disturbance of function, notwithstanding the slight stiffness and large amount of swelling.

Treatment by ordinary methods for synovitis has little effect; improvement is rapid when mixed mercury and iodid treatment is employed. *Dunlop, Edinburgh Medical Journal*, December, 1904, p. 516. *Arch. Ped.* June, 1905.

THE LATE POISONOUS EFFECTS OF ANESTHETICS.—A. D. BEVAN and H. B. FAVILL (*Journal A. M. A.*, September 2) report the case of a girl, aged twelve and a half years, from whom a gangrenous ovarian tumor with twisted pedicle was removed. The operation was done under chloroform and took a long time and an unusually large amount of the anesthetic. The patient did well until forty-four hours after the operation, when there appeared an acute toxic delirium with rapid pulse, tonic muscular contractions, moderately high temperature, and later, increased temperature, Cheyne-Stokes breathing, irregular heart action and death 110 hours after the operation. The autopsy, by Dr. Hektoen, seven hours after death, showed advanced fatty change in the liver, at the periphery of the lobules, and congestion, etc., of kidneys, spleen and lungs. The authors give an extended review of the literature of similar cases, and conclude that anesthetics, especially chloroform (ether to a very limited degree), can produce a destructive effect on the liver and kidney cells, and on the muscle cells of the heart and other muscles, causing fatty degeneration and necrosis, very like that occurring in phosphorus poisoning. The most constant and important injury is that to the liver, and is in direct proportion to the amount of anesthetic used and the length of the anesthesia. Some individuals appear to be specially susceptible to these effects, and certain conditions, such as age—the younger the patient the greater the danger—those lowering the general vitality, various intoxications, exhaustion, lesions involving fatty degenerations and chronic affections of the liver and kidneys are also probable predisposing causes. As a result of the liver lesions, toxins are produced either from the liver cells themselves or as a result of their failure in their normal eliminative functions, and these may produce a defi-

nite symptom-complex, consisting of vomiting, restlessness, delirium, convulsions, coma, Cheyne-Stokes respiration, cyanosis, icterus in varying degree, and usually terminating in death. It is probable that milder degrees of this poisoning are observed as transient after-effects of chloroform. The condition is a hepatic toxemia, and in the opinion of the authors, as definite a pathologic entity as a pancreatitis with fat necrosis. Acetone, diacetic acid, and beta-oxybutyric acid are by-products, but not essential poisons in this toxemia. The liver lesion is the one responsible for the symptoms and the fatal result. In the fatal cases, death is almost invariably due to chloroform; ether is seldom the cause of death of this kind. Hence, chloroform should never be used with conditions such as have been mentioned as favoring this toxemia, nor for very prolonged operations. The importance of limiting the duration of the anesthesia, when chloroform is employed, is especially emphasized by the authors.—*Medical News*, October 14, 1905.

#### BOOK REVIEWS.

**CARR'S PEDIATRICS.** The practice of Pediatrics by Eminent Authorities. Edited by Walter Lester Carr, M. D., Consulting Physician to the French Hospital; Visiting Physician to the Infants' and Children's Hospital, New York. In one very handsome octavo volume of 1014 pages with 199 engravings and 32 full page plates in colors and monochrome. Cloth, \$6.00, net; leather, \$7.00, net; half morocco, \$8.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906.

Here is still another good book on Pediatrics, and this one is a volume of more than a thousand pages, the work of fourteen well known writers and teachers in Pediatrics.

The editor thinks that a comprehensive and authoritative survey of each of the major divisions of medicine is necessary from time to time to record its latest development and to enable those who desire to master it as a whole, or

to post themselves on special points, to do so with facility. With this object, three companion volumes have been arranged covering respectively Gynecology, Obstetrics, and Pediatrics, and furnishing a compact presentation of the world's best knowledge upon these closely connected departments.

The volume that we are considering is the work of well known authorities in America and England.

The general plan of the book is to draw a clear clinical picture of disease and then an equally clear exposition of the best methods of treatment.

Each article represents the personal opinion and the clinical experience of its writer, so that the reader has before him a rich and matured presentation of clinicians and teachers of the two great English-speaking countries.

Very justly, a large space has been given to infant feeding, disorders of nutrition, respiration and circulation, and to the contagious diseases. The object of this book is constantly to describe the conditions most intimately associated with disease in children and not those which are more common in adult life and rarely seen in children.

The line between Pediatrics and General medicine has been carefully drawn; the space has been used for a full Pediatric study in a volume of convenient form and size.

Most questions have been omitted and only such pathological matters are introduced as are essential to the full knowledge of disease. Under the able editorship of Carr, the book has been most conveniently arranged both for reference and for study.

The editor has refrained from a personal contribution and has used his skill purely in the editorial capacity. This he has done very well indeed, and the book is a valuable contribution to Pediatric literature. It would have been well to supply a hand magnifying glass for the charts on pages 30 and



31, as they are totally illegible without one. The articles on infant feeding are clear and carefully prepared. A little more amplification of the methods of percentage feeding would be desirable, but, on the whole, this chapter is one of the most valuable in the book, to both the senior student and the practitioner. It occupies eighty-five pages and is space well allotted.

Bovaird's section on diseases of the alimentary tract, of one hundred and forty-five pages, is one of the most important and valuable sections in the whole book. Attention is called to the fact that in infants fed entirely upon milk, lactic acid is a constant constituent of the gastric contents.

The acid has its origin in the milk sugar. Lactic acid probably exercises some influence upon digestion, as is shown by the ease with which mothers' milk is digested, where the amount of milk sugar is conducive to lactic acid formation.

Another point that Bovaird lays stress on is of considerable importance in the diagnosis of pyloric obstruction, and that is the duration of the stay of food in the infant's stomach. It is well known that the contents of the stomach pass very rapidly into the duodenum, and that, in a young infant, the stomach may be entirely empty one half-hour after nursing.

Epstein gives one and one-half hours as the maximum time for the evacuation of the stomach in a breast-fed child. As the stomach grows and larger amounts of food are taken, it of course requires longer to empty it, and Unger has told us that even in the resting stomach of the infant there will be a small quantity of yellowish fluid, which contains all the constituents of the gastric secretion in a concentrated form and gives the biuret reaction.

We can hardly agree with the writer in his statement of the extreme rarity of cirrhosis of the liver in childhood.

It was a very rare disease when the reviewer wrote his paper more than fifteen years ago, but since then, like any other affections that have been overlooked, it is less rare, and a careful search at the post mortem table and in the records will show that infantile cirrhosis occurs more than once in twenty thousand hospital cases, even in these latitudes.

We are pleased to note that Weir's operation of stitching the omentum so as to establish a collateral circulation is recommended.

It is also a pleasure to note that the treatment of intussusception is slowly but surely being placed upon a purely surgical basis where it belongs. This is about what Bovaird says: "In any case, inflation or injection is allowable as a preliminary treatment if the method does not lead to procrastination in the performance of laparotomy." This is good, but how much better would it be to perform the laparotomy at once and save valuable time while the gut vitality is good and before toxemia has set in to an alarming degree. It is now generally admitted that infants bear laparotomy much better than was formerly believed. Statistics show that operations on the first or second day are successful in about 50 per cent. of the cases.

Individual operators report better results in limited numbers of cases. Nor can we agree with the writer that the position of the appendix is more variable in the earlier years of life. The sites that he mentions as being very unusual ones are very often seen in the adult. Indeed, within two weeks, the reviewer has seen, in adults, an appendix fast to the right perineal tissue, another to the gall bladder, and a third to the tissue.

We do, however, fully agree with the statement that appendicitis is almost entirely a surgical problem; omit the

word almost and our argument is absolute.

One reads this section of Bovaird's with a feeling of satisfaction and commendation. We know of no book that presents the subject in a clearer or more forcible manner both for students and practitioners.

The chapter on Infectious Diseases, particularly that on Tuberculosis, is a very strong one, and adds much to the value of the book. It is a masterly presentation of the subject and is particularly strong in its chapter on treatment, which after all said and done, is of the most interest to the average hard-working practitioner. We indorse this chapter without qualifications.

Indeed, as we read this book, comparisons of one article with the other seem hardly fair, as they are all so uniformly good that we do not care to make any further selection for commendation.

The book is an excellent one, and it would be manifestly to the advantage of every physician to have this entire series of three volumes at hand, but the publishers, having in mind the convenience of those who are interested in one or two individual departments, have issued each volume as a separate book, complete in itself, and any volume of the series may be purchased separately.

W. A. E.

Consul Brittain supplies from Kehl the figures concerning the amount of liquor consumed in Germany during the five years, 1900-1904, inclusive. According to published statistics each inhabitant consumed yearly  $6\frac{1}{2}$  quarts of wine,  $129\frac{1}{2}$  quarts of beer, and 9 quarts of brandy. The per capita cost was \$11.20, including children and women. The average for male citizens over 15 years would be \$37.36. For a population of 60,000,000 persons the liquor expenditure figures out at \$672,588,000.

Consul-General Guenther, writing from Frankfort, supplements this re-

port by contrasting these figures with other German expenses. For public schools the Empire spent, in 1904, the sum of \$99,722,000; for working people's insurance, \$104,244,000, and for the army and navy, \$203,847,000. All these great public enterprises cost the German nation less than two-thirds of their alcoholic drink bill.

G. H. Kenyon regards as a certain and speedy mode of *treatment of lumbago* the local application of tartarated antimony by thoroughly rubbing into the painful part unguentum antimonii tartarati B. P., twice a day until the pustules characteristic of antimony make their appearance. By this time the pain is greatly relieved, if not quite gone, and the patient is practically well. Along with this treatment he administers a saline aperient mixture containing sodium salicylate. If the ointment is thoroughly rubbed in, one or two applications are usually sufficient. The ointment should not be rubbed in longer than necessary to relieve the pain, or after the pustules have come out, as this makes the skin sore.

*In tonsillitis, croup, quinsy and diphtheria* cold applications are extremely serviceable, because the circulation, heat and fever in the parts are thereby diminished and in consequence, inflammatory conditions subside. These applications can be made by the use of cold towels or napkins around the throat or neck.

A teaspoonful of a mixture of two ounces each of tinct. Jamaica ginger and tinct. capsicum, administered in one-half teacupful of hot water before meals and at bedtime is said to be an unequalled *remedy for colds and hoarseness*.

The borate or soda is advised in the *treatment of epilepsy*. It must be given in large doses and persisted in.

# SOUTHERN CALIFORNIA PRACTITIONER.

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

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## EDITORIAL.

### THE GOLDEN RULE IN PRACTICE.

One of the prominent practitioners in Riverside county writes us as follows:

*"To the Editor:*—I have just finished reading your 'The Physician's Duty to His Fellow Practitioner,' and feel like offering you sincere congratulations for the expression of such golden thoughts. Although an almost 'shut in' country practitioner, the thoughts therein expressed did me more real good than anything I have read in a long time. Could your hearers steel themselves to follow your advice I have every reason to believe that not one of them but would say and feel that they were happy in having very nearly followed the 'Golden Rule,' which, in our profession, it seems to me is very seldom done. I am sure that I shall often recall your advice and will be the better for having read your article."

### CLIMATOTHERAPY.

The PRACTITIONER presents in this number some excerpts in the "Twenty-one Years Ago Column" from an article which appeared originally in the PRACTITIONER of October, 1886. The author of the paper, Dr. J. P. Widney, now Emeritus Dean of the College of Medicine of the University of Southern California, therein calls attention to climatological changes in Southern California coming under his observation during the prior twenty years, that is, during the period between 1866 and 1886. The comments on these observations and the conclusions he drew therefrom are of more than usual interest and are well worth the reading, not only because of their scientific value but because of the interesting side light they throw upon the development of this section of the Golden State.

It is a fact with which some of the PRACTITIONER's latter-day readers may



not be familiar, that this journal was established largely for the purpose of providing a press medium in which the observations by medical men, on the climate of Southern California and the Great Southwest might be recorded. Through its twenty-one volumes the *PRACTITIONER* has endeavored to be faithful to this purpose and the large number of interesting and valuable articles on the climatology of the Southwest which have been printed in its columns, demonstrate how well this end has been attained.

The excerpts from Doctor Widney's article, printed in this issue, are an evidence of the character of the scientific observation and spirit of a previous generation of Los Angeles physicians, and should be an incentive to present and future practitioners to continue the good work along these lines, which was so well begun by the pioneers of our profession in the Great Southwest.

#### THE FUNDAMENTAL SENSATIONS OF THE SKIN.

The "Distribution of Afferent Nerves in the Skin" was the title of the paper read by one of the foreign guests of the American Medical Association at its recent Boston meeting. The subject was considered by Professor Max von Frey, Director of the Physiologisches Institute of the University of Wurzburg, Germany, and his paper was the opening article of the *Journal* of September 1.

In his brief survey, Professor Frey gave a masterly presentation of some of his researches in one of the most in-

teresting fields of the physiology of the nervous system.

The consideration of cutaneous sensations in our ordinary text-books of physiology is by no means clear, and this is to be regretted, since these sensations of the skin and subcutaneous tissue have at times a quite important clinical significance.

Take for instance, the recent edition of Professor Stewart's excellent *Manual of Physiology*. In speaking of the sensations dependent upon the afferent nerves of the skin, he states: "Under the sense of touch it is usual to include a group of sensations which differ in quality . . . but agree in this, that the end organs in which they are perceived are all situated in the skin, the mucous membranes, or the subcutaneous tissue. Such are the common tactile sensations—including pressure and tickling—and the sensations of temperature. . . . The sensation of pain, although it cannot be absolutely separated from these, ought not to be grouped along with them. . . . The peculiar sensation associated with voluntary muscular effort, to which the name of the muscular sense has been given, also deserves a separate place. . . . The simplest form of tactile sensation is that of mere contact. . . . This soon deepens into the sensation of pressure; and eventually the sense of pressure merges into a feeling of pain."

Compare the above with the following by Howell of Johns Hopkins, who considers the subject in this wise: "Modern physiology has shown, however, that the cutaneous nerves mediate

at least four different qualities of sensation—namely, pressure, warmth, cold and pain. Our so-called touch sensations are usually compound, consisting of a pressure and a temperature component and also very frequently an element of muscle sense. . . . The surfaces in the interior of the body, on the contrary, . . . have only nerves of pain but no sense of touch or temperature. Of these cutaneous senses, three—pressure, warmth and cold, may be grouped with the exterior senses, the sensations being projected to the exterior of the body, into the substance causing the sensation. . . . The pain sense, on the other hand, belongs to the group of internal senses. . . .”

Frey in his paper before the American Medical Association stated that the sensory functions of the skin were based on the four fundamental qualities mediating the sensations of warmth, cold, touch and pain, and that corresponding to these functions, the afferent nerve supply of the cutaneous surface was four-fold one, the specific end organs of one set of nerves being responsible for the sensation of warmth, another for cold, a third for touch and a fourth for pain. The most irritable points of these specific end organs were those parts nearest the surface and the distribution of these points was punctiform. Thus, roughly estimated he held there were on the skin of the trunk and limbs some 30,000 warm spots, some 250,000 cold spots and about 500,000 touch spots. The pain spots were very numerous, but investigators had not been able to decide on any definite number.

Concerning the distinctions made by neurologists between light and deep pressure, von Frey attributes the perception of light pressure of form and of size to the nerves of the skin, but the perception of deep pressure, he thinks Sherrington has shown, to reside largely in the muscle spindles and perhaps to a much lesser extent in the corpuscles of Pacini and Golgi, which are to be found in the fibrous membranes, in tendons and in joints.

Professor von Frey presents also the details of some very interesting investigations of these fundamental skin sensations, outlines their limitations and concludes that clinical observation is of quite as much importance as physiology, in unraveling the wonderful and mysterious functions of the skin.

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#### THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

On Thursday morning, October 4th, the College of Medicine of the University of Southern California began its twenty-second annual session and the occasion is a pertinent one, therefore, to call attention to an editorial which was printed in the *PRACTITIONER* of October, 1886, and which is excerpted in the “Twenty-one Years Ago Column” of the present issue of this journal.

The development of this institution and its influence on the medical profession of the Southwest during the last score of years is too well-known to need any comment. It should be gratifying to Southern Californians to know that “the avowed aim of the college to do none but thorough work,” which aim was promulgated at its founding twenty-two years ago, has only been accentuated with the passing of time.

The twenty-second session which opened on the 4th inst. gives every promise of most successful work.

## EDITORIAL NOTES.

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Dr. Norman Bridge has returned from Europe.

Dr. A. L. Macleish spent the month of August in Idyllwild.

Dr. A. C. Orr, formerly of Covina, has located in Whittier.

Dr. Claire W. Murphy recently spent two weeks in Idyllwild.

Dr. D. W. Edelman has returned from a vacation at Lake Tahoe.

Dr. W. V. Coffin of Whittier is spending a few weeks East.

Dr. Frank Gobar has located in Fullerton, Los Angeles county.

Dr. C. W. Girdlestone of Riverside spent a month at Oceanside.

Dr. H. G. Brainerd has returned from a month's outing at Catalina.

Dr. H. W. Fenner of Tucson took his outing in Southern California.

Dr. J. C. Hearne of San Diego is a police commissioner of that city.

Dr. Marcia Gillmore of Pasadena is spending a few weeks in Chicago.

Dr. M. B. Huff of Corona has been taking his vacation at Long Beach.

Dr. W. B. Sawyer of Riverside has invented a new tire for automobiles.

Dr. Frank S. Byington of Los Angeles has been two weeks in Catalina.

Dr. F. C. Mattison of Pasadena has been taking his vacation at Idyllwild.

Dr. Ira E. Brown has located in Kelvin, Arizona, where he will practice.

Dr. C. A. Shepard of Needles has been spending his vacation in Catalina.

Dr. H. A. Hess of San Francisco is now located in that city at 749 Hayes street.

Dr. W. A. Sauls of Kingman, Ariz., was recently visiting friends in Los Angeles.

Dr. Hugh Walker has been appointed health officer of Elsinore, Riverside county.

Dr. J. C. Norton of Phoenix, Ariz., was in Los Angeles a few days in September.

Dr. and Mrs. Charles Mayo of Rochester, Minn., were recently visitors in Los Angeles.

Dr. R. N. Looney of Prescott, Arizona, is taking a post-graduate course in New York City.

Dr. Max Werder, formerly of San Francisco, has located in Colton, San Bernardino county.

Dr. C. G. Stivers of Los Angeles is spending a few weeks doing post-graduate work in Chicago.

Dr. A. F. Zimmerman has located at 112 South Townsend street, Highland Villa Tract, Los Angeles.

Dr. Rea Smith and Dr. Guy Cochran of Los Angeles have been taking their vacations in Santa Barbara.

Dr. A. L. Gustetter, marine hospital surgeon, Nogales, Arizona, recently spent a few days in Los Angeles.

Dr. J. T. Reynolds, lately of San Dimas, has moved to Los Angeles where he will practice his profession.

Dr. Oscar J. Kendall, formerly of Riverside, has located in San Diego with offices in the Granger Block.

Dr. Sarah E. Maloy, of Riverside, has returned from Chicago where she has been doing post-graduate work.

Dr. Clarence W. Pierce has returned from a six weeks' trip East. He spent considerable of his time in Boston.

Dr. P. G. Cornish of Albuquerque, N. M., has been spending some time in the hospitals of New York City.

Dr. C. H. Jones of Tempe, Arizona, President of the Territorial Board of Medical Examiners, has returned home after spending several weeks in Los Angeles and vicinity.



Dr. F. M. Pottenger of the Pottenger Sanatorium spent a week recently getting a much needed rest at Idyllwild.

Dr. H. E. Stroud, formerly of Phoenix, Ariz., has located in Los Angeles and is associated with Dr. J. T. Stewart.

Dr. A. G. Willis, recently of Pasadena, has accepted the position of general manager of a sanatorium at Lake Charles, Louisiana.

On August 28, Dr. Hugh Walker, a prominent physician of Elsinore, and Miss Maud Timmis of the same city were married.

Dr. E. H. Wiley of Los Angeles, while on a hurry call recently, had an automobile collision and barely escaped with his life.

The British Customs announce that Holland sends the worst butter that is received in England and the United States the best.

Dr. H. Haynes Koons of Tombstone, Arizona, has been devoting a few weeks to visiting the hospitals of Philadelphia and New York City.

Miss Belle Sumner Angier had a very interesting appreciation of the Barlow Sanatorium in the *Los Angeles Evening News* of September 13.

Dr. W. F. Freeman, division surgeon of the Santa Fe Railroad, with headquarters at the Needles, has recently been a visitor to Los Angeles.

Dr. R. W. Craig of Phoenix, Ariz., has returned after spending two months in the Chicago hospitals. He returned home by way of Los Angeles.

Dr. Fred Williams, an alumnus of the Long Island College Hospital, has located in Bisbee, Arizona, where he will be associated with Dr. David E. Broderick.

Dr. Philip King Brown has closed the Miradero Sanatorium of Santa Barbara. After spending a few weeks in making extensive repairs, the institution will be reopened.

In Germany, 1905, there were 3,316,593 hectares planted in potatoes, one hectare being about two and one-half acres, from which were produced 48,323,353 metric tons.

Dr. A. F. Jonas, chief surgeon of the Union Pacific at Omaha, and Dr. D. S. Fairchild of Des Moines, Ia., were recently in Los Angeles inspecting the California Hospital.

Dr. James P. Booth of Los Angeles has been nominated by the Non-Partisans for County Coroner, and will contest the election of Dr. R. S. Lanterman, the Republican nominee.

The United States supplied more than one-half of the wheat imported into Japan during 1905. The Japanese are rapidly adopting the use of wheat and flour instead of an exclusive rice diet.

Dr. W. Edward Hibbard of Pasadena has just returned from Berlin, where he spent the last several months. He devoted himself especially to work on the eye, ear, nose and accessory sinuses.

Dr. A. W. Vanneman and Dr. Bim Smith of Hermosillo, Mexico, have been taking several weeks' vacation in Los Angeles, and during that time were seen daily around the hospitals of that city.

A private hospital and sanatorium is being constructed at Tucson by eastern capitalists and will be open about December first with Dr. H. P. Shattuck, formerly of New York, as resident physician.

Dr. Frank W. Thomas of Claremont has just returned from Chicago, where he has been taking a post-graduate course at the Chicago Polyclinic and doing work in various other hospitals in that city.

Dr. and Mrs. C. N. Bledsoe, of Bisbee, Arizona, were honored with an enthusiastic charivari on their return home from Los Angeles on September 10. The doctor passed out the cigars and everybody was happy.

Dr. Adelbert Fenyes of Pasadena has

returned from a delightful summer trip through the United States and Canada. The doctor is quite a noted naturalist, and in his ramblings added many fine specimens to his collection of beetles.

Dr. J. C. Lindsay of Los Angeles, who had a serious accident in an elevator over a year ago, brought suit against the proprietors of the building asking \$20,000 damages and received a verdict in a Los Angeles court for \$5,000.

Dr. G. A. Fielding, who has been a surgeon at the Soldiers' Home Hospital, Santa Monica, for several years, and who was formerly resident physician at the California Hospital, Los Angeles, has located at Sawtelle, Los Angeles county.

Dr. Ancil Martin of Phoenix, Arizona, who has so long been a prominent member of the Board of Education of that city, and also an active member of the profession of Arizona, has recently returned from New York City, where he has been doing hospital and post-graduate work.

Sir James Crichton-Brown, England's chief authority on mental diseases, says: "Rapid locomotion is simply a craze, and fast motoring tends to homicide mania. The confirmed motorist becomes sluggish in intellect and excitable in temper."

The Republicans have nominated Dr. R. S. Lanterman of Los Angeles for Coroner of Los Angeles county. The doctor graduated from the Baltimore University School of Medicine, and has been practicing in Los Angeles County ever since.

Before the automobile, the motor car and omnibus motor were introduced in London, there were 6,000 veterinary surgeons in that city. The number has greatly decreased and, according to one in authority, there will be in three years hence room for only 300.

Dr. J. H. McBride can well be proud of the success of Las Encinas, his beautiful establishment at Pasadena for the

treatment of nervous diseases. The institution is conducted on ethical principles, and deserves the support of the profession and the public.

Dr. Henry Dietrich has been appointed chief surgeon of the A. C. Company at Clifton, Arizona, with Dr. T. B. Smith as his assistant. Dr. A. C. Gillon will take Dr. Dietrich's former place at the A. C. Hospital at Longfellow, Arizona, while Dr. H. D. Wiley will remain at Metcalf.

Dr. Norman H. Morrison, chief surgeon of the Santa Fe, was married in Los Angeles, September 5, to Miss Irma Rhodes, formerly of Kansas City. After a trip to Eastern cities they will be established in Dr. Morrison's elegant home at 1263 West Adams street, Los Angeles.

Dr. F. N. Staples of Amador county, after spending eighteen months in States prison, has been given his liberty. He was convicted of murder and sentenced to be hanged, but the Supreme Court has just rendered a decision that the evidence introduced was not sufficient to warrant conviction.

Dr. A. D. Houghton, who is Councilman and physician in the city of Los Angeles, was taken quite ill recently while in attendance at the City Hall. The doctor is a regular dynamo and keeps at high tension both professionally and politically. We are glad to know that he is rapidly recovering.

Dr. Lewis S. Thorpe, the Los Angeles oculist, was married on October 10 to Miss Edith Liliencrantz of Oakland. Miss Liliencrantz is a daughter of Dr. August Liliencrantz, and Dr. Thorpe a prominent physician of Los Angeles, trustee of the State Normal School, a member of the University Club, and other social organizations.

China is actively fighting the opium habit and has asked India to consent to an annual reduction in the import of opium to China, which would have the effect of extinguishing the trade in ten

years, and is about issuing an imperial edict condemning the use of opium and forbidding the employment in the government service of any opium-eater.

The Barlow Fete, a social charitable function that was given for the benefit of the Barlow Sanatorium for indigent consumptives, lasted two evenings and one day and netted the institution \$13,581.16. There never was a more worthy charity, and we congratulate the people who thus had the opportunity of assisting Dr. and Mrs. Barlow in this most laudable work.

After January 1 it will again be "Dr. George C. Pardee." The doctor and his friends made a gallant fight for re-nomination for governor, but the organization was against him. Dr. Pardee says: "As soon as my term as governor of California expires I will leave Sacramento for the old homestead in Oakland and will take up professional life as an oculist where I dropped it four years ago."

Dr. Boardman Reed, late of Philadelphia, has located in Los Angeles with offices in the Union Trust Building, corner of Fourth and Spring streets. Dr. Reed, who is the author of one of our principal text-books on diseases of the stomach and intestines, will devote himself to affections of the gastro-intestinal tract including its annexes and rectal diseases, as well as disorders of metabolism dependent upon indigestion and faulty diet.

Mrs. Mary Stephenson Powers, wife of Dr. L. M. Powers, city health officer of Los Angeles, died at her home, 1040 Lovelace avenue, on August 28, after an illness of many months. Mrs. Powers was a very philanthropic and public-spirited Christian woman. She was a prominent member of the First Presbyterian Church and, until her illness, the president of the Ladies' Aid Society. She was also an active member of the Ebells Club.

Dr. Mark A. Rodgers, of Tucson,

Arizona, has an interesting paper in the September number of "Charities," entitled: "Some Observations on Tuberculosis by a Dweller in the Desert." Dr. Rodgers speaks especially of the excellent effect of the climate of Arizona on children. He says "in the lower altitudes of Arizona they play in the open air without wraps day after day in the warm sunshine and grow to be lusty and well."

Dr. David Bell of Long Beach recently had a very unpleasant experience. He was answering the telephone at 3 o'clock in the morning when he received an electric shock which rendered him unconscious for half an hour. When Dr. Bell first answered the phone he felt a slight thrill, and just after he had jotted down the name and address of the person requiring his services, he received a strange shock which stunned him. He was miserable for several days.

Dr. E. Payne Palmer of Phoenix, Arizona, returned September 3rd from a two months' visit to Alaska. He stopped over one day in Los Angeles and one day in San Francisco. He says the summer climate at Skagway, Alaska, is, he believes, the finest in the world. The temperature while he was there stood at about 70 degrees and was very equable. From Skagway he took the White Pass and Yukon Railroad to White Horse. This railroad is one of the most extensive pieces of engineering work in the world. The scenery along the railroad is something magnificent, and not to be compared with any thing else in the West. Take it all in all, the doctor's trip was very interesting and enjoyable.

The Association of American Medical Colleges has adopted the following: "Colleges in membership in this Association may honor the official credentials presented by students from other colleges having the standard requirements maintained by members of this Association, excepting for the fourth year of their course, but no member of this As-



sociation shall admit a student to advanced standing without first communicating with the college from which such student desires to withdraw, and receiving from the dean of such college a direct written communication certifying to the applicant's professional and moral qualifications and to the exact work he has done in said college."

This is a very good precaution, as there are students around with fraudulent credentials. The fact that fraudulent credentials were used in two of the Baltimore medical colleges led to the adoption of the above section by the College Association. Medical colleges everywhere are now insisting that the young men desiring to enter a medical college must have at least the equivalent of a high school education. Physicians should impress this on all young men who confer with them in regard to entering upon the study of medicine. The facts are that a medical college should really not matriculate a student until he has had not only the high school education, but two years in a college of liberal arts.

Mr. Harry Ellington Brook, who has charge of the department, "Care of the Body," in the *Los Angeles Sunday Times*, recently published in his department the following as a model advertisement for quacks and patent medicine men. We think that Mr. Brook has done himself proud and that his effort is a great improvement over the average quack ad. This is the way it read:

#### ALL ABSOLUTELY FREE.

#### COME, LET US REASON TOGETHER.

Are you sick? Have you aches, pains, itches, stitches? Are you depressed? Are you elevated? Do you feel lack of appetite after a heavy meal? Are you inclined to drink, when thirsty? Are you restless, when infested with fleas? Are you in love? Are you in politics? Do you breathe rapidly, after running up to the top of a high mountain? Can you feel your heart beat? Do you object to bad smells?

All these are sure signs of dangerous, deadly and incurable diseases. There is only one chance for you. Only one! Delay not a moment, but hasten immediately to the office of that wonderfully gifted

and most altogether marvelous superman,

#### REVEREND PROFESSOR DOCTOR

#### ENRICO ELLINGTONIO BROCOLI,

H. B. (Human Benefactor); D. F.; P. P.; X. Y. Z., etc., etc., etc., Postgraduate of the Hydrocephalous Institute of Borriboola-Gha, the seventeenth son of a seventh father, born with a gall, a full set of teeth, and the gift of prophecy. He will tell you, at a glance, what you have in your head, your stomach, and your pockets.

The Doctor is assisted by his immense, highly-trained and highly-salaried staff of world-eminent specialists, who fill

#### SEVEN LARGE CIRCUS WAGONS

when the establishment moves. This brilliant and unexampled array of intellect includes physicians, surgeons, dentists, dermatologists, osteopaths, orthopedists, ophthalmologists, yogis, naturopaths, mahatmas, chiropodists, palmists, acrobats, neurologists, prestidigitators, clairvoyants, alienists, clairaudients, electricians, and plumbers, all standing at the highest summit of their profession. Their services are all at your disposal, ABSOLUTELY FREE, although some of them receive salaries greater than that paid to the President of the United States.

Try Dr. Brocoli's combined

#### MILK PUNCH, OZONE, LIMBURGER AND HOT AIR CURE.

The Doctor also administers his precious and wonderful

#### Liquid Essence of Diamondiferous Diatoms,

manufactured solely for him in a marvelous machine that cost \$743, 468.94 (not including the freight).

#### ABSOLUTELY FREE!

#### ABSOLUTELY FREE!

Reverend Professor Doctor Enrico Ellingtonio Brocoli, H. B. (Human Benefactor,) D. F., X. Y. Z., etc.

The Doctor-Professor also administers, either as a draught or per rectum, or hypodermically, as may be indicated, the concentrated quintessence of hydrophobic skunk juice, from an animal of this rare species captured at enormous expense in the mountain fastnesses of Central Arizona, by a band of intrepid frontiersmen, specially employed by the Doctor, for the purpose.

Visitors are invited to see the extraction of the essence, daily, at 3:30 a.m.

Another rare, expensive and miraculous remedy is Dr. Brocoli's

#### RADIO-HERBAL AFRICAN DEVIL JUICE.

This extraordinary remedy is extracted from an exceedingly rare plant, discovered by a blind missionary in the depths of one of the densest and most impenetrable jungles of the Dark Continent, where a human foot never trod. The plant is held sacred by the fierce giant, man-eating cannibals who inhabit that region. It can only be gathered when the moon is exactly three-quarters full, at midnight of a day when the 29th of February falls on a Friday. Every drop of this marvelous elixir of life has cost

barrels of human blood. It is used specially by the Doctor for the purpose of raising the dead. No matter how dead you may be, do not hesitate. The Doctor will cure you. In the cases of those persons who have been devoured by animals more than five hours, and consequently digested, and of those who have been cremated, three weeks' time will be required, owing to the extra difficulty of assembling and fitting the parts.

#### ALL ABSOLUTELY FREE.

Remember, that all these priceless gifts are absolutely free, the Doctor being influenced solely by his love of humanity. He is enabled to do this, having a private fortune of \$115,000,000 invested in Confederate bonds.

Come and hear the free, scientific,

moral lecture delivered by the Doctor every afternoon, entitled, "The Activity of the Brain and the Agility of the Hand," illustrated by a troupe of educated, trained fleas. This is a highly moral lecture to which you may safely bring your unborn child.

Remember to address:

**REVEREND PROFESSOR DOCTOR  
ENRICO ELLINGTONIO BROCOLI.**

Offices: Box 23, Station X, Third Floor,  
Ring the fire alarm.

**Come Unto Me, All Who Labor, and I  
Will Do the Rest.**

N. B.—This advertisement will appear only once.

P. S.—A special invitation extended to the feeble-minded.

## TWENTY-ONE YEARS AGO IN LOS ANGELES.

EXCERPTS FROM THE SOUTHERN CALIFORNIA PRACTITIONER, VOLUME I, NUMBER 10,  
OCTOBER, 1886.

"Climatic surroundings unquestionably have a certain power in changing the types of man. Equally true it is that man, to a certain extent, has it in his power to work material changes in climate. In pursuing the line of investigation proposed as the especial field of this journal, it may not be amiss to investigate the changes which have already been wrought in climate through human agency in certain sections of Southern California. . . .

"Eighteen years ago, when I settled in Los Angeles (having spent, however, the preceding six years upon the Pacific Coast, so that I was accustomed to note its climatic peculiarities), a very limited population possessed the country.

"What is now Los Angeles City was then a country town of a few thousands. Wilmington, San Bernardino and Anaheim were the only other centers of population in the great series of plains which face upon the ocean for a hundred miles at this point, and they were small towns with population numbered only by the hundreds. Each of these towns, with the exception of Wilmington, was surrounded by a small area of tilled and irrigated lands with here

and there an orchard or a vineyard of a few acres. Outside of these limited circles spread the broad plains, for hundreds of miles, brown and bare in the summer heat, and tramped by thousands of horses, cattle and sheep. In some of the lowlands, however, were great fields of mustard, covering many thousands of acres. I remember driving for some miles in a buggy by a narrow road through one of these fields, and standing up upon the buggy, was unable to see across the tops of the growth. Here and there along river bottoms was a narrow rim of willows, but the great expanse of plains was bear of timber as a rule. . . .

"The climatic characteristics of that time may then be thus summed up: High summer temperature in day, increased in autumn by fires; rapid radiation of heat and quick chill at night except as so far counteracted by the burning mustard fields; comparatively low winter temperature; an atmosphere marked by dryness except during continuance of rain current; prevalence of strong westerly winds; rainfall somewhat irregular and rain current very apt to be broken up prematurely by the westerly winds.

"During the eighteen years which have elapsed since the time to which the foregoing description applies, the population of this series of plains has increased many fold. Numerous towns are scattered over it. The waters of the various rivers and mountain streams have been taken from their beds and turned over the land for miles by means of irrigating ditches. Artesian wells, numbering into the thousands, have been bored, and are used to irrigate large areas of country. Hundreds of thousands of acres of the upland have been broken up by the plow and are yearly planted in small grain. All of this land now absorbs the winter rains which formerly, because of the hardened crust, ran off to the sea. Large sections of country have been planted in vineyards and orchards and are under the highest state of cultivation. Other large areas are, by means of irrigation, kept covered with a growth of green grass the whole year for dairying. Extensive forests have been planted, while almost every farm has its orchard and its grove of trees for fuel. The country which then was devoid of timber except the willows of the river banks, now looks in many directions like a land only partly cleared of its natural forest growth. While a certain amount of oak and chaparral has been cut off along the base of the mountains for fuel, the timber growth of the country at large has been increased a hundred fold.

"These are changes which man has wrought in the physical features of the country. What have been the results climatically? . . .

"The lowered surface temperature has again had its effect in a somewhat diminished force of the daily sea breeze. Fifteen years ago, in my driving, I found the broad Santa Monica plain lying between Los Angeles and the sea each summer swept by the strong afternoon winds until the surface was devoid of

vegetation, and the roads cleared of dust until they were hard and bare as a floor. Now, the plain retains its vegetation and the roads are covered with a thick layer of dust. . . .

"I am well aware that mere personal observation, apart from accurately kept meteorological observation by means of instruments, is at best an unreliable method of compiling scientific facts, and subject to much questioning and doubt; yet, in the absence of the more reliable sources of information, it is not without value, and I think the following conclusion may be fairly summarized from the foregoing as to the climatic changes which the Anglo-Teuton is making in this, to him, new home:

- 1st. A lowering of the day temperature.
- 2d. An increase of night temperature.
- 3d. An increase in atmospheric moisture during the dry season.
- 4th. An increased precipitation from dew and fog.
- 5th. An increased tendency to summer rain.
- 6th. A diminution of the force of the daily sea breeze.

These may be again more briefly summarized as an increased equability of climate."—*Excerpt from an original article on "Climatic Changes Which Man Is Working in Southern California," by J. P. Widney, A. M., M. D., Professor of the Principles and Practice of Medicine in the College of Medicine of the University of Southern California.*

\* \* \*

"Thus in our contest with pathogenic micro-organisms we have at command three agencies, one or other of which is to be employed as circumstances require, viz., protective vaccination, high temperature, and certain substances which are directly destructive through chemical action.

"Discussion of this subject in any greater detail is not at this time ad-



missible; but, with the foregoing facts before us, we have the principles upon which true disinfection and antiseptics must be based; and it is only by a careful and thorough observance of these principles that progress is possible in hygiene and sanitary science."—*Excerpt from an original article on "The Life and Destruction of Micro-Organisms," by John L. Davis, A. B., M. D., Lecturer on Materia Medica and Therapeutics in the Medical College of the University of Southern California.*

\* \* \*

"The PRACTITIONER takes an especial pleasure in calling attention to the opening of the second year of the College of Medicine of the University of Southern California. Located as it is at a point many hundreds of miles distant from any similar institution, and forming as it does one of the colleges of a strong and successful University; its success was assured from the beginning. Its first year, while marked by a fair share of the difficulties which always attend the opening of a new school, was also marked by a prosperity in the highest degree gratifying. The indications for the coming year are of still greater prosperity.

"The class will, from the applications now on file, be at least doubled. Some slight changes have been made in the chairs of the faculty, adding still more to the efficiency of a corps of lecturers which, even in the first year of the college work, averaged unusually well.

"The clinical facilities and the opportunities for the practical study of anatomy by dissection are all that could be desired.

"The avowed aim of this college is to do none but thorough work. And to make sure of the same high plane of instruction in the future, it has embodied in the articles of incorporation from the University a section stipulating that the standard of education shall ever be

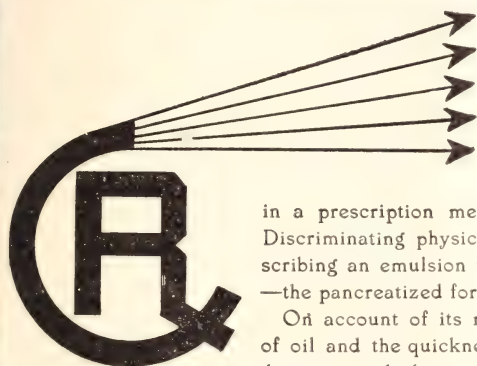
kept on a par with that of the recognized leading schools of the United States.

"The class could have been trebled during the past year if the college had consented to lower its standard, or to admit of irregularities in the course. But to all applications only one answer has been returned: 'This college can run with small classes if necessary, but the work done shall be thorough. The standard, as published in the announcement, will not be lowered, but on the contrary, will be steadily raised.' The college in following this course has the satisfaction of knowing that it commands the respect of similar institutions throughout the land.

"The second collegiate year begins Wednesday, October 13th. Further information may be had by consulting the college announcement published elsewhere in this journal."—*Excerpt from an editorial entitled "The College of Medicine of the University of Southern California."*

\* \* \*

"Probably not many of our readers are aware of the serious illness of Dr. G. W. Lasher. He is, we learn, under treatment in the Mt. Sinai Hospital, New York City. Dr. Lasher went East this summer with the intention of pursuing his studies in microscopy. On his way he visited Niagara Falls. At this place he delayed too long in the Cave of the Winds and caught a severe cold which resulted in a tubercular trouble in the knee joint. The prognosis cannot at present be fully decided, but an amputation is feared, while the most favorable result anticipated is ankylosis of the knee joint. It is with grief that we chronicle the fact, for he will be missed by a large circle of friends in this city. His co-workers in the college express great regret in losing his valuable assistance, and the students are unanimous in their appreciation of his services and the desire for an ultimate and speedy recovery."—*Editorial Note.*



## What Follows R

in a prescription means much to the patient. Discriminating physicians, therefore, when prescribing an emulsion usually specify Hydroleine—the pancreatized form of cod-liver oil.

On account of its remarkably high percentage of oil and the quickness and thoroughness of its digestion and absorption, larger quantities of oil can be assimilated within a given time in the form of Hydroleine than in any other way. Hence, results follow promptly. Write for sample and literature. Sold by all druggists.

THE CHARLES N. CRITTENTON CO., Sole Agents,  
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"Dr. David C. Barber (Miami Medical College, O.) will fill the chair of Histology and Microscopy in the Medical College of the University of Southern California during the illness of Dr. Lasher."—*Editorial Note.*

\* \* \*

"The PRACTITIONER misses the services of one of its editors, Dr. Walter Lindley. The doctor being completely run down after a hard year's work, concluded to try for a few months the tonic effect of an Eastern trip."—*Editorial Note.*

\* \* \*

"Dr. J. H. Utley has been taking a post-graduate course in New York, and will return to the Professorship of Physiology in the Medical College of Southern California at the beginning of the term."—*Editorial Note.*

"Dr. W. L. Wills, who has been spending several weeks in the Eastern States, is expected home the first of this month."—*Editorial Note.*

\* \* \*

"Dr. H. H. Maynard has been appointed County Physician for Los Angeles County, vice Dr. Walter Lindley, resigned."—*Editorial Note.*

\* \* \*

Witherspoon thought it was a good chance to get some medical aid without paying for it.

"How do you do this morning, Colonel?" asked Dr. Soonover.

"Poorly, doctor, poorly. For some time past I have been suffering from weakness. As you can see I can hardly walk. What shall I take, doctor?"

"Take a hack," replied the doctor, gruffly, as he strode off.—*Exchange Note.*

## MISCELLANEOUS.

## THE BARBAROUS TREATMENT OF THE INSANE.

Denouncing present methods of caring for the insane, which he declared to be crude, inadequate and barbarous, and calling upon his fellow practitioners to urge upon the members of the State Legislature to amend the medical practice act so as to properly define "practicing medicine," Dr. G. W. Libby of Spokane, president of the Washington State Medical Association, opened the annual convention in Spokane last month. There was a large attendance of physicians, and there were two special guests, Hon. Albert E. Mead, Governor of Washington, and Mayor Floyd L. Daggett of Spokane, who both made brief addresses, the former saying he would like to borrow some parts of Dr. Libby's speech and bring them before the next meeting of the Legislature.

"I have undertaken a betterment of the statute law with relation to the prevention of tuberculosis," Governor Mead added, "and I believe that whatever medical science has discovered we ought to adopt. There is only one way to stay the white plague and that is the strong arm of the State and the commonwealth should be stretched out as a barrier to stop it."

Dr. Libby did not mince words in his address in speaking of the care of the insane. He said on that point: "Our system of caring for the insane is inadequate, crude and in some respects barbarous. The process of law by which the unfortunate sufferer is committed to the care of the State is unworthy of the civilization of the twentieth century; it is a relic of the dark ages."

He advocated the establishment of an institution for the criminally insane, declaring that a person who escapes the penalty for crime upon the grounds of insanity should not be turned loose to

become a further menace to public safety.

Papers were read on the following subjects by the undermentioned:

Discussion on pleurisy led by Dr. William Douglass of Tacoma; "Diagnosis and Prognosis of Pleuritic Effusions," by Dr. M. C. Robins of Spokane; "Clinical Course and Treatment," by Dr. J. Sutherland of Spokane; discussion, led by Dr. William Shannon of Seattle; "Angina Pectoris, Pseudo-angina and Palpitation," by Dr. J. W. Bailey of Seattle; "Bradycardia, Tachycardia, Syndrome and Arrhythmia," by Dr. William House of Portland, Ore.; discussion, led by Dr. H. W. Dewey of Tacoma; "Treatment of Organic Heart Lesions," Dr. H. W. Howard of Prosser, Wash.; "Osteomyelitis, Classification, Etiology and Pathology," H. W. Reed of Seattle; "Clinical Course and Differential Diagnosis," Dr. W. N. Keller of Tacoma; "Treatment," Dr. A. A. Matthews of Spokane; discussion, led by Dr. E. H. Brown of Tacoma; "Headache, Significance and Treatment," Dr. S. Sargentish of Tacoma.

These officers were elected for the coming year: President, Dr. J. H. Lyons of Seattle; Vice-President, Dr. E. L. Kimball of Spokane; Second Vice-President, Dr. E. E. Shaw of Tacoma; Secretary, Dr. C. H. Thompson of Seattle; Treasurer, Dr. G. H. Greer of Tacoma. The conventions will be held as follows: Seattle, 1907; Tacoma, 1908; Spokane, 1909.

The officers for the Washington Association for the Prevention and Relief of Tuberculosis are: President, Dr. C. H. Smith of Seattle; Vice-President, Dr. E. E. Heg of Seattle; Second Vice-President, Dr. Wilson Johnston of Colfax, Wash.; Secretary, Dr. W. R. M. Kellogg of Spokane; Treasurer, G. S. Brooke of the Fidelity National Bank of Spokane.



**ALCOHOLISM IN ENGLAND AND FRANCE.**

The report of the committee presented to Parliament by command of His Majesty states that:

"The abuse of alcoholic stimulants is a most potent and deadly agent of physical deterioration.

"Alcoholic persons are specially liable to tuberculosis and all inflammatory disorders.

"Evidence was placed before the committee, showing that in abstinence is to be sought the source of muscular vigor and activity.

"The lunacy figures show a large and increasing number of admissions of both sexes which are due to drink.

"The following facts, recognized by the medical profession and placarded all over France by the Government, are published in order to carry out the recommendation of the committee and to bring home to men and women the fatal effects of alcohol on physical efficiency:

(1) Alcoholism is a chronic poisoning, resulting from the the habitual use of alcohol (whether as spirits, wine, or beer) which may never go as far as drunkenness.

(2) It is a mistake to say that those doing hard work require stimulants. As a fact no one requires alcohol as either food or tonic.

(3) Alcohol is really a narcotic, dulling the nerves, like laudanum, or opium, but is more dangerous than either in that often its first effect is to weaken a man's self-control, while his passions are excited; hence the number of crimes which occur under its influence.

(4) Spirits, as usually taken, rapidly produce alcoholism, but milder alcoholic drinks, as beer, and even cider, drunk repeatedly every day, produce, after a time, alcoholic poisoning with equal certainty.

(5) The habit of drinking leads to the ruin of families, the neglect of social duties, disgust for work, misery,

theft and crime. It leads to the hospital, for alcohol produces the most various and the most fatal diseases, including paralysis, insanity, diseases of the stomach and liver, and dropsy. It also paves the way to consumption, and frequenters of public houses furnish a large proportion of the victims of this disease. It complicates and aggravates all acute diseases; typhoid fever, pneumonia, and erysipelas are rapidly fatal in the subject of alcoholism.

(6) The sins of alcoholic parents are visited on the children; if these survive infancy they are threatened with idiocy or epilepsy, and many are carried away by tuberculous meningitis, or phthisis (consumption).

(7.) In short, alcoholism is the most terrible enemy to personal health, to family happiness, and to national prosperity."

The above is being placarded by the municipal authorities throughout London and other English cities.

**TWO DOZEN ANTI-PLAGUE COLDEN RULES.**

Remember plague is more "Death" than disease.

Never visit suspected or plague-stricken houses.

Never alter a well-regulated diet.

Wash the hands frequently.

Avoid excesses in diet and wines.

Cook food well and preserve from insects.

Heat serving plates to a high temperature.

Cooking utensils wash with boiled or water of undoubted purity.

Rather drink weak tea than suspicious water.

Avoid excess in exercise and bathing.

Never handle dead rats.

Destroy your vermin.

Never neglect a trifling wound, cold, or dyspepsia.

Protect the lower limbs well.

Be vaccinated and revaccinated if you can.

Keep good fires in winter.

Avoid wet feet.

Preserve the head with sunshades in summer.

Use if you can the mosquito net.

Never exchange pipes.

Never kiss the plague suspect.

Avoid plague apparel unless fumigated.

Never fear, rather be cool, calm and collected.

Remember cleanliness is next to godliness.

—*From Japanese Text-book on Plague, by Ishigami MacDonald.*

## BOOK REVIEWS.

**THE PROPHYLAXIS AND TREATMENT OF INTERNAL DISEASES.**—Designed for the use of practitioners and advanced students of medicine. By F. Forchheimer, M. D., Professor of Theory and Practice of Medicine and Clinical Medicine, Medical College of Ohio, Department of Medicine of the University of Cincinnati; Physician to the Good Samaritan Hospital; member of the Association of American Physicians, The American Pediatric Society, etc. Cloth. 652 pages. New York and London: D. Appleton & Company, 1906.

This is one of the most satisfactory works on prophylaxis and therapeutics that has come into our hands. It is satisfactory because it is comprehensive, explicit and practical and it meets unusually well, therefore, the demands of the general practitioners for whom it has been especially written. It represents the ripe experience of more than thirty years' of an extensive clinical experience in private and hospital work, an experience that was constantly associated with faithful study and conscientious observation. The reviewer speaks from first hand knowledge on this point, for it was his privilege to sit on the benches under Dr. Forchheimer and to also serve under him as an interne.

To individualize in a work of such superior merit as the volume which Forchheimer has given us would be difficult. The style of the author is excellent, being clear-cut and interesting, and the arrangement of the disease groups and the consideration of the details concerning the prevention and

treatment of individual diseases is logical and comprehensive. Physiological methods and dietetics are by no means overlooked, but are given careful and satisfactory consideration. In drug treatment Forchheimer stands out in refreshing relief to those therapeutic nihilists who can see but little value in the remedies of the pharmacopoeia. The directions for the use of drugs are carefully outlined and their special indications definitely indicated.

The entire work impresses itself as being of far more value than the ordinary therapeutic "system" of several volumes, by a large number of editors, because the author has here, in compact manner, given in rounded form his own methods of the treatment of each disease and its various complications, not neglecting to present for consideration also, such methods as may have a considerable following, but which he, himself, from personal observation, or for other reasons, can not see his way clear to commend.

The typographical make-up of the volume adds materially to its value, the type being clear and easily read and the print being on a paper of good quality.

We have not the least hesitancy in recommending this work and we are certain its merit will insure for it a wide sale among general practitioners, who are as a class, looking for books that are authoritative without being dog-

# *Antiphlogistine*

(Inflammation's Antidote)



## THE SPATULA

oftentimes will make unnecessary

## THE SCALPEL

if it be used for the application of Antiphlogistine hot and thick in the various inflammatory and congestive conditions.

# ANTIPHLOGISTINE

Depletes Inflamed Areas  
Flushes the Capillaries  
Stimulates the Reflexes  
Restores the Circulation  
Bleeds but saves the Blood

**THE DENVER CHEMICAL MFG. CO.**  
**NEW YORK**

Chicago  
Denver  
San Francisco

London  
Sydney  
Montreal



matic, comprehensive without being redundant, up-to-date without being committed to faddisms and clear-cut in diction without being dry and uninteresting. Forchheimer's work is a book of this type and as such the reviewer commends it most heartily. C. H. K.

SAUNDERS' QUESTION COMPENDS, NO. 1.

—Essentials prefaced, of Philosophy, especially for students of medicine. By Sidney P. Budgett, M. D., Professor of Physiology in the Medical Department of Washington University, St. Louis. Second edition, thoroughly revised, by Haren Emerson, A. M., M. D., Demonstrator of Physiology in Columbia University (College of Physicians and Surgeons) New York. Arranged with questions following each chapter. Illustrated. Philadelphia and London: Cloth, 246 pages. Price, \$1.00, net. W. B. Saunders & Company, 1903.

To consider so large a subject as physiology within the brief limits of a compend is no small task and is one that can be approached in a number of ways. Budgett and Emerson have relieved their volume of much of the usual compend dryness and stiltedness by presenting a readable text after the lecture style, instead of the chopped-up method of the ordinary compend. In places, as, for instance, in the consideration of the sympathetic nervous system, a much clearer presentation is given than is met with in some of the larger text books on physiology. The illustrations are excellent and add to the value of the work.

A NON SURGICAL TREATISE ON DISEASES OF THE PROSTATE GLAND AND ADJUTEN. By George Whitfield Overall, A. E. M. D., Chicago. Cloth, 228 pages. Rowe Publishing Company, 1906.

This little book attempts to give what its title implies, an exposition of non-surgical methods of treating the prostate gland and its adnexa. For persons who are interested in that line of work, and especially those who have electrical equipments in their offices, the volume should be of service. Illustrations and case histories help much to amplify the text.

A REMEDY FOR CHOLERA. C. D. Ussher, inspired by Koch's statement that quinine in 1-1000 to 1-2500 solution de-

stroyed the cholera germ in from ten to thirty minutes, has used the drug in the treatment of cholera, giving ten-grain doses every hour till bile reappears in the stools; from forty to eighty grains have been given. While under the old treatment nearly every case was fatal, under this medication ninety percent. of the patients recovered, including some who were almost moribund. The routine method is described as follows: Quinine sulphate, ten grains every hour till ricewater stools ceased and bile re-appeared; sweet spirits of niter, dry cupping, heat and friction for suppression of urine, saline injections when the wrist pulse had disappeared. Some patients recovered under the quinine without injections.

As regards *drugs in bronchitis in children*, Winters believes that in severe cases the drug of unfailing universal efficacy is aconite. To restrain and limit the pressure of blood within the bronchial arteries and branches of the aorta is the aim. Through this drug arterial pressure is promptly circumscribed. Maximum, frequent doses during the first hours, diminished, less frequent doses after four or six hours; early abandonment. It should be given in water only—tasteless, non-nauseating, it does not affect the appetite.

It is said that *arsenicum album* is efficacious in ptomaine poisoning, whether caused by inoculation, inhalation or swallowing of unwholesome food. In this class of cases are included wounds inoculated with animal ptomaines, and food poisoning caused by the ingestion of spoiled fruit, cheese, ice cream, sausage, fish, clams, oysters, lobsters and canned goods, in which ptomaines or toxins of a mixture of both are responsible for their deleterious action.

*Thuja occidentalis* is a valuable antiseptic application in all varieties of cancer where there is sloughing.

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## A SYMPOSIUM ON ANAESTHESIA.

### CHLOROFORM.\*

#### ITS INDICATIONS AND ADVANTAGES.

BY DAVID D. THORNTON, LOS ANGELES, CAL.

A hasty review of the literature on the subject of anaesthetics furnishes a most unsatisfactory task.

Ether, chloroform and the mixtures each have their advocates and conflicting statements force the reviewer to form his own conclusions, largely from his personal experience and his knowledge of the physiological action of the various anaesthetics.

The depressing action of chloroform on the heart and respiration and its tendency to lower blood pressure will, in my opinion, always make ether the anaesthetic of choice in the average operative case.

Also the secondary toxic effects directly due to the anaesthetic employed has been shown to be greater in chloroform than ether. This is especially important in operations requiring considerable time.

The ever-present financial consideration, the ease of administration, the pleasantness of the drug, the quickness

of its action and the small quantity required are some of the factors leading most of us to carry a bottle of chloroform always in our grip.

Plethoric subjects with full bounding pulse, excitable and hysterical individuals whose heart's actions call for a sedative rather than a stimulant, do far better with chloroform than ether.

Atheroma, arterio-sclerosis, aneurism, and conditions of weakened vessel walls forbid the stimulating effect of ether. In operations for the relief of cerebral hemorrhage, brain tumors and in most of the cases of brain surgery, chloroform is the better anaesthetic.

As chloroform does not excite an excessive secretion of saliva and mucus its use is preferred in operations about the mouth, larynx and upper air passages; especially is this true where the mirror is to be employed.

Chronic diseases of the lung are said not to contraindicate ether.

Acute inflammations of the lung tis-

\*Part of a Symposium on Anaesthesia read before the Los Angeles County Medical Association, November 2nd, 1906.

sue and bronchi certainly give chloroform the preference.

On account of the toxic effects of chloroform on already diseased hepatic cells, ether is the anaesthetic in liver surgery.

In nephritics, opinion is divided between ether and chloroform. Because of the increased blood pressure and the fact that most of us were taught that ether was an irritant to these cases, chloroform will be chosen.

In administering ether to alcoholics the only effect produced may be a comfortable jag for the patient and chloroform will be substituted.

Among Western and Southern men,

chloroform will be used in obstetrics. Its effects in these cases have been a source of wonderment to me. Oftentimes in forceps deliveries we are compelled to trust its administration to a member of the family or an indifferent nurse, and rare indeed are the accidents following its use. The patient quickly awakens and nausea is almost unknown.

Chloroform will be used in operations requiring but little time, especially with children and the aged.

The ideal anaesthetic perhaps is yet to be discovered, but when my appendix is removed, I shall insist that ether be employed by the open, that is, by the drop-by-drop method.

## ETHER.\*

### ITS INDICATIONS AND ADVANTAGES.

BY H. G. MCNEIL, M.D., LOS ANGELES, CAL.

It would seem to be almost a superfluity at this stage of medical progress to present before a body of physicians and surgeons a paper extolling the virtues of ether and the advantages it holds over other agents employed for the purpose of producing surgical anesthesia. But the very fact that others are being constantly used is justification enough for the few words I have to say in support of my subject.

I shall not attempt to enumerate or discuss any of the many small points which every anesthetizer must familiarize himself with, but will simply endeavor to emphasize its advantages and show how some of its unpleasant effects may be obviated.

Of course no one claims that ether is an ideal anesthetic or perfectly safe. Far from it. And it is to be hoped that we shall not be so narrow as to discourage the promotion and trial of new ones, but at the same time, I believe it is the consensus of opinion that

ether is the safest anesthetic which we now possess, and that we should leave experimentation along newer lines to the large institutions and laboratories where it can be carefully and systematically carried out. It is at these very places that ether is most highly prized. The establishment of Ether Day at the Massachusetts General Hospital was a very apt way of expressing their appreciation. The life of the patient is temporarily entrusted to the anesthetizer and it is too sacred a trust to be experimented with.

The mortality from major operations of the selection type has been reduced to a minimum, but there remains the danger from the anesthetic which unfortunately still contributes a considerable percentage of the deaths from surgical procedures. The immediate deaths are frequent enough but they form only a part of the total number.

To nicely administer ether, the anesthetizer must be cautious, skillful and

\*Part of a Symposium on Anaesthesia read before the Los Angeles County Medical Association, November 2nd, 1906.



thoroughly familiar with the phenomena which he is to induce. If he will realize that each time he is dealing with a problem in physiology rather than a patient, he will be more attentive to his task and learn to watch more closely for the many little signs which enable him to pilot his patient through with a minimum of shock and danger. Unfortunately, physiologists have not cleared to our complete satisfaction the fundamental principles involved in ether narcosis. Nor have they made any important additions to our knowledge since the extensive researches of Meyer and Overton. They independently found that anesthesia was caused by a solution of the lipid constituents of the cells by the absorbed anesthetic. All fat solvents being anesthetic if they enter the cell, and the anesthetic being proportioned to the factor: Solubility in lipid, divided by solubility in water. The chemic composition of ether makes it much easier of absorption than the other inhalation anesthetics, but the concentration in the serum required, 1-400, to produce unconsciousness by ether, is so much greater, that the time required to induce it is usually longer. However, the fact that even with a theoretically perfect mixture and proportion, a prolonged anesthesia will cause death, must lead us to believe that there is some change in the composition of the cell body not explained by the theory of Meyer and Overton.

The anesthetizer must also have a thorough knowledge of the physiology of respiration. If he will keep its phenomena in mind he will save himself many uncalled-for alarms and some embarrassing circumstances.

The chief respiratory center undoubtedly lies in the medulla and is stimulated by the quality of blood passing through it. If a patient is made to breathe deep or rapidly, either from a verbal request or distal stimulation, there is immediately a change in the proportion of oxygen and carbon cir-

culating in the blood. It necessarily follows that there must soon be a change in the respiratory rhythm until a physiological equilibrium can be established. The reverse also holds true. This is one of the reasons why a patient being anesthetized should never be asked to take a long breath.

You will pardon my digression into the field of physiology, but I believe it is essential, and a little investigation along these lines will do much to clear up the unenviable reputation ether has earned through the efforts of some who are not sufficiently familiar with its mode of action.

The recent work of Bevan and Favill on the physiology of acid intoxications and the late poisonous effects of anesthetics is a valuable one. In support of ether I cannot do better than quote from it: "These toxins produce a definite symptom complex which makes its appearance from 10-150 hours after anesthesia. This symptom complex consists of vomiting, restlessness, delirium, convulsions, coma, Cheyne-Stokes respiration, cyanosis, icterus in varying degree, and usually terminates in death.

"It is probable that milder degrees of this poisoning are recovered from and that the transient icterus noticed after chloroform anesthesia without other evident cause is due to such poisoning, and many cases which exhibit restlessness, fright, mild delirium, drowsiness, etc., after anesthesia may be due to the same cause.

"This hepatic toxæmia following anesthesia is almost invariably due to chloroform in the fatal cases. Ether is seldom the cause of a death of this kind."

This serious and even fatal effect of chloroform which heretofore has not been generally recognized must still further limit the use of this powerful and dangerous agent.

Persons of a lymphatic tendency are known to take anesthetics badly, and the existence of a status lymphaticus

has undoubtedly been the cause of death in many heretofore obscure cases. However, in searching the literature, I have not been able to find a single well-authenticated case of death from status lymphaticus where ether has been the anesthetic employed.

The stimulating effects of ether on the cardiac and respiratory systems and the manner in which it raises blood pressure are well-known facts and need no comment. Pure ether vapor never gives rise to the sudden primitive syncope which so often proves fatal.

There are no contraindications for the use of ether. Any patient who can stand the shock of an operation can take it. Those with nervous, lung, heart, liver and kidney lesions all do better on it than on any other agent now in use, providing it is carefully and properly administered.

Cases of fracture of the skull, intracranial hemorrhage or concussion require stimulation and very little anesthesia. Here ether drop by drop is ideal.

In pulmonary affections—it is here that ether has been most strenuously objected to and entirely without cause. If there is any class of patients who need all the available support it is this class and as ether stimulates the heart and respiration and at the same time raises the blood pressure, it must tend to lessen the work thrown on the unimpaired lung tissue. These patients require a greater percentage of oxygen than any other class and if given, there will be little trouble with coughing and excessive secretion of mucus. Pneumonia following operations was formerly laid to ether, but in the light of more recent observations, we can no longer blame it. It is probable that too concentrated vapor, chilling or embolism are responsible for it. I approve of Grossman's aphorism: "Pulmonary affections following etherization are not the fault of the ether, but of the anesthizer."

Grave cardiac lesions do not contraindicate etherization for long operation unless the patient has to sit up to breathe, in which case any anesthetic would be hazardous. Those who require stimulation or have an intermittent pulse do better under ether, but great care must be exercised to bring them through the stage of excitement. Hare says that he is strongly convinced that when accidents do occur, the ether is not to blame, but rather the shock of the operation.

An organic lesion of the kidney is often benefited, at least symptomatically, rather than damaged by a prolonged etherization.

Is ether irritating to the kidneys? I think not. Unfortunately medical opinion is widely divided on this point. During full narcosis the secretion of urine is diminished in direct proportion to the depth and length of the anesthesia. According to the experiments of Thompson, in ether narcosis, when the curves of urine outflow, kidney volume and blood pressure are compared, there is found to be a closer correspondence than is the case with chloroform. The chlorides are increased and the nitrogenous elements diminished and if there is any irritation, it is probably due to the retention of the latter element which can work no structural changes. On several occasions I have observed urine previously laden with albumen clear up entirely twenty-four hours after an etherization. Edebohl rarely uses chloroform in these cases. Diabetic patients are no exception to the rule.

The preparation of children for an operation and the choice of an anesthetic should not differ materially from that of an adult. In order to overcome any irritating effects of the ether, lessen shock and preserve the bodily heat, an abundance of oxygen is necessary and this can be best supplied by pure fresh air.

As a class the plethorics are apt to

give the etherizer more scares than any other. A little mucous in the mouth, a dusky face and embarrassed respiration and a loss of corneal reflex are often times signs of great distress to the etherizer, but if he will give plenty of air, keep in mind the amount of ether and the degree of concentration which he has already administered, and the stage of anesthesia which his patient must be in at the time, he will save himself a great deal of anxiety and annoyance to the operator.

A few words now as to the method of administration. As yet no ideal method for the administration of ether has been devised. Until such is the case it probably makes little difference which inhaler is used, providing of course that the anesthetizer is thoroughly familiar with it and the results he wishes to obtain from its use.

Many elaborate and more or less complicated inhalers have been devised from time to time and used with varying degrees of success. The latest to claim attention is the one invented by Gwathmey which is so constructed that it will automatically mix a desired percentage of the warmed vapors of chloroform or ether with oxygen at the will of the operator. It is very similar to those devised by Braun and by Wahlgumuth, both of which are being used to some extent in the clinics of Germany. While theoretically, they seem near perfection, I am informed by those familiar with their use, that they are far from satisfactory, and even dangerous in the hands of any but an expert. The excellent results reported are due rather to the skill of the anesthetizer than to the apparatus. When we consider that chloroform as a general anesthetic is dangerous and that it is a debated question as to whether it is possible to actually administer a warm ether vapor we find small justification for the use of these complicated inhalers. The published experiments made upon animals are imperfect and far from convincing.

There is probably no better inhaler for general use than the Bullard, with which you are all familiar. The use of it and others of a similar pattern is generally known as the closed method and requires considerable more skill than it does to use the open method which is now becoming so popular. This latter method is called open because it permits of a free mixture of air with the ether vapor. The mask generally used consists of an Esmark chloroform inhaler covered with a dozen layers of gauze. It is simple and clean. The ether is sprinkled on this and the degree of concentration controlled by covering it entirely or in part with a towel. With a little practice it will be found easy to get a mixture of any required strength depending on the needs of the patient.

By covering the mask with a hot wet towel, the full effect of the closed method can be obtained. Whatever inhaler is used, it should never cover the eyes as the etherizer should watch them as he does the pulse.

A chloroform-ether or ethyl chloride-ether sequence can likewise be used with this mask without removing it from the face.

I believe the open method is the safest and most generally satisfactory which we now possess, and that in some one of its forms, it will continue to grow in popularity until it is universally used. If there is any time when we need fresh air and plenty of it, it is when we are under the shock of a surgical procedure. The guiding principle in the use of ether should be to maintain a perfect anesthesia and yet at the same time reduce the asphyxial factor to a minimum.

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Olive oil is exceedingly valuable in the treatment of *sprained, bruised or contused parts*, applied warm on absorbent cotton and kept hot. It acts as nutrition to the part. It diffuses the heat and is a marked soothing agent.



## ANAESTHOL.\*

## ITS INDICATIONS AND ADVANTAGES.

BY J. LEE MAGALDEN, M.D., LOS ANGELES, CAL.

Anaesthol combines in a stable chemical union 47 per cent. of Ethyl Chloride, 33 per cent. of chloroform, and the balance of ether, and possesses the distinguishing advantage of volatilizing at a temperature slightly above that of the body, so that its elimination is properly regulated by the lungs *without imposing any strain on other parenchymatous organs, so that accumulation or retention involving risk to the patient is excluded.* It is a clear, transparent fluid of agreeable odor, with a specific gravity very close to that of the blood and a boiling point of 104 degrees Fahrenheit.

With the administration of anaesthol the patient is kept just sufficiently under the influence of the anaesthetic to enable the operator to do his work with convenience, and in consequence of this almost complete equilibrium that is maintained between absorption and elimination, it frequently happens that the patient never completely loses the reflexes.

There are no sudden changes in pulse rate, volume, or pressure. Anaesthesia comes on gradually and progressively, and return to consciousness is prompt, in fact, frequently strikingly so.

Vomiting after the use of anaesthol is rare, compared to the frequency of this occurrence after the administration of other anaesthetics. Headache, general malaise and general systemic affections so often witnessed after chloroform and other anaesthesia, are also very rarely met. Not a single case of bronchitis or pneumonia is on record as a result of anaesthol narcosis. Heart, lung and kidney affections are *not considered contraindications* to the use of anaesthol, but in several personal cases the symptoms of a previously ex-

isting nephritis were temporarily slightly increased.

Some eighteen months ago I reported to this Society a series of 600 anaesthetizations with anaesthol, giving the indications for, and advantages of its use for general anaesthesia, in both long and short operations.

Since January 1st, I have given anaesthol 188 times, of which I have kept record, and wish to give a further report as to its action in a varied number of conditions.

The cases recorded in this series are as follows:

Eye Enucleations .....	4
Extraction of Teeth .....	6
Mastoid .....	2
General Surgery .....	52
Tonsils and Adenoids .....	13
Pelvic Surgery .....	52
Abdominal Sections .....	27
Rectal .....	15
Obstetrical operations .....	10
Empyema .....	1

Total .....188

In this series, the average time for complete surgical anaesthesia was three minutes. Vomiting occurred in 42 cases. The vomiting was slight and of short duration, except in 4 cases, where the nausea was severe and prolonged.

*No alarming symptoms were seen in any of this series,* and in one empyema case, (which was started with ether, at the request of the surgeon,) I changed to anaesthol on my own responsibility, and the alarming stertor and cyanosis at once gave place to quiet, regular respiration, with good color and pulse.

CONCLUSIONS:—Anaesthol is especially indicated in the aged, alcoholics, and others of like nature, because of its rapidity of action and the absence of stage of excitement.

In cardiac and pulmonary affections,

\*Part of a Symposium on Anaesthesia, read before the Los Angeles County Medical Association, November 2nd, 1906.

because it does not affect the pulse rate, volume or blood pressure.

In renal disease, because it is almost totally eliminated by the lungs. In abdominal surgery, because it is the quietest, steadiest anaesthetic, and can be

given for almost any length of time without saturation of the patient.

The patient is conscious and comfortable within a few minutes of cessation of anaesthetic, instead of being "dopy" and hysterical for hours.

## SPINAL ANAESTHESIA.\*

### ITS INDICATIONS AND ADVANTAGES.

BY F. S. DILLINGHAM, M.D., LOS ANGELES, CAL.

Spinal anesthesia has been used by many surgeons since it was introduced by J. Leonard Corning of New York in 1884.

Perhaps Andrew W. Morton of San Francisco has used this method more than any other man in the world. This form of anesthesia has been found to be safe, especially when used for operations below the diaphragm, and is particularly useful in cases of advanced heart, kidney or lung diseases.

After an exploratory incision the patient may be informed of the conditions found and with his consent a radical operation may be performed at the same sitting. If given for a cystoscopic examination the conditions may be explained to the patient while the picture is before your eye.

Under Tropacocain analgesia there is frequently no nausea or vomiting. If the patient's bowels have been cleaned out and he has been prepared with the same care as for a general anesthetic this rarely happens. When present it usually occurs within the first ten minutes, or in long operations, just before the patient leaves the table. The nausea rarely lasts longer than five minutes and it passes away as soon as the stomach is emptied.

When the patient returns from the table he may have his usual number of pillows; if he has no nausea he may have nourishment at once.

I have had no opportunity to test

this method for operations above the diaphragm, but Morton says: "It can be used for operations in localities where it is extra hazardous to administer a general anesthetic, on account of blood entering the larynx, as in excisions of the tongue or where there is danger of involving a nerve in a ligature, as the recurrent laryngeal in removal of the thyroid gland. The great advantage to be gained in using this method in operations about the buccal cavity can hardly be appreciated till tried."

Tropacocain is an alkaloid obtained from a Japanese plant resembling coca. The powder is sterilized in small vials at 275 degrees Fahrenheit for fifteen minutes.

In giving this anesthetic the patient is given a hypodermic injection of 1-30 grain of strychnia to guard against any possible bad effects of the Tropacocain. He then sits on the operating table with his feet resting firmly on the seat of a chair and his back is thoroughly prepared. With the back well bowed to separate the spinous processes, a few drops of a 1-2 per cent. sol. of cocain are injected at the level where the needle is to be introduced. The three-inch platinum needle with short beveled point is then introduced in the median line between the spinous processes and until a drop of spinal fluid appears. A Luer syringe containing the dry Tropacocain is then attached and the piston

\*Part of a Symposium on Anaesthesia read before the Los Angeles County Medical Association, November 2nd, 1906.

slowly withdrawn. When all of the cocaine is dissolved the solution is forcibly injected into the canal and on withdrawing the needle the small puncture is closed with collodion on a small pledget of cotton, or by a strip of gauze and adhesive plaster. The patient is immediately placed in the recumbent position as this lessens any tendency to nausea. In weak patients the needle may be introduced with the patient lying on his side. The surgeon may begin his work just as soon as the field of operation can be made ready. If the surgeon wishes to operate above the diaphragm the patient's head is lowered to the Trendelenburg position and usually work may be begun in ten minutes. The anesthesia usually lasts from one-half to two and one-half hours, depending on the amount used. The amount required will depend entirely upon the amount of work to be done and on the individual patient; from 1-2 grain for simple examinations to 2 grains for abdominal work.

Some patients are so nervous that they will not keep their back still long enough to give the preliminary injection of cocaine, and in this work when it comes to using the needle the back must be kept perfectly still, for the least variation will stop the flow of spinal fluid. A crooked spine will add to the difficulty of using this method, but with a little patience the right way will usually be found.

I think this method is a boon to the aged who come to us for operations as there seems to be less shock from the operation and the patient's strength is saved by reason of less vomiting.

In all I have used this method seventy-nine times and to show the practical scope I find that it was given for 33 prostatectomies, 8 external urethrotomies, 7 rectal operations, including one for cancer, 6 for vesical calculi, 6 for curettage, 6 for perineal fistulae, 4 for cystoscopic examinations, 2 for inguinal hernia, 1 for varicocele and 1 for vaginal hysterectomy. The ages range from 20 to 83.

I do not believe in the introduction of the needle above the third lumbar vertebra, as forcible injection together with gravity will carry the anesthetic to the higher levels.

In the above series of cases the Tropacocain produced perfect anesthesia. There were no headaches or alarming symptoms such as we formally had when cocaine was used for this purpose.

General anesthesia is promised and used, should sensation return before the operation is completed. The earlier doses were not quite large enough and a few whiffs of a general anesthetic were used in a few cases just at the close of the operation but this has not been necessary for at least seventy of the cases noted.

## SCOPOLAMINE-MORPHINE-ANAESTHESIA.

### ITS INDICATIONS AND ADVANTAGES.

BY Z. T. MALABY, M.D., PASADENA, CAL.

In May, 1900, Schneiderlin first published his experience with a new method of general anaesthesia produced by the aid of a combination of scopolamine and morphine. Since then a number of reports have been published in Ger-

many and Austria and in this country by Ries and Seelig. The method undoubtedly has great advantages and will probably come into more extended use, as it is better understood.

Scopolamine is an alkaloid extract

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from the roots of *hyoscyamus niger*. Its sister alkaloids are hyoscyne, dubosine, atropine and hyoscyamine.

Of those who had investigated scopolamine, some stated that it was isomeric with hyoscyne, others that the effect of the combination was due largely to morphine, still others that the drug was dangerous and uncertain in its action. Lamphear reports 100 cases where hyoscyne was used as a general anesthetic with excellent results.

The best resumé of the physiological action of scopolamin is given by Steinbuechel. He states:

1. Small doses raise blood-pressing by stimulating the vasomotor center. Large doses lower it by influencing the cardiac excitomotor mechanism.

2. Pulse usually slowed a trifle, but is ordinarily not influenced by small doses. Large doses cause a vagus pulse.

3. Cerebral cortex rendered less excitable when stimulated by the Faradic current. Sleep is induced, but not analgesia.

4. Respiration not influenced by small doses. Large doses, slow respiration.

5. Sweat, mucous and saliva secretion markedly diminished.

6. Mydriasis.

7. Motor end-apparatus supplying the intestine paralyzed. Tone of the splanchnic increased.

8. Excreted by the kidney.

The recent experimental work of Crile shows that morphine lessens the intensity of many of the afferent nerve impulses reaching the vasomotor centers, as the result of stimulation of the peripheral nerves, and thereby lessens the susceptibility to shock. Scopolamine exerts a distinct influence in raising blood-pressure and thereby also aids in preventing shock. So, from the point of view of prophylaxis, the combination of the two drugs strongly recommends itself. Only he who has witnessed a series of ether administrations preceded

by scopolamine-morphine injections can appreciate what a boon these drugs afford both to the patient and to the operator.

Ordinarily, this tablet administered hypodermically one hour before the operation will produce the desired effect. In robust individuals, I have found it necessary to repeat the dose one-half hour following the first injection, and in subjects of weak resistances, a small amount is preferable.

First of all it markedly lessens the quantity of anaesthetic necessary. About four ounces of ether per hour of operation are used when the drug is administered skillfully and carefully. In a personal communication to me, Dr. T. L. Bennett of New York tells me that he uses about four ounces of ether per sixty minutes of anaesthesia and that for two-hour operations, he requires about six ounces. This averages three and a third ounces per hour. We used barely a fraction over two ounces per hour. It has already been pointed out how great a desideratum it is to administer a minimal quantity of ether.

After the administration of scopolamine-morphine, the patients are in a peaceful state of mind, and go under the influence of the general anesthetic without passing through the general state of excitement. Salivation is almost invariably absent, thus adding another safeguard against aspiration pneumonia. After their return to bed the patients lie absolutely quiet and awaken without the slightest excitation. After remaining awake for a short period, they usually doze off again, or at least remain quiet and peaceful. The first twenty-four hours following the operation is attended by much less pain and discomfort than in cases where scopolamine is not administered. These advantages: Lessened amount of anaesthetic necessary, absence of salivation, avoidance of the stage of excitement, marked reduction in the liability to vomit, and quiet and freedom from pain

after operation, have been confirmed by Tuffier of Paris, Israel and Dork of Berlin and by Robertson of our own country. (Robertson used hyoscine instead of scopolamine.

Roth has collected 3799 cases in which this form of anesthesia was used, and estimates that the number actually has reached 4000. He discusses the eighteen cases in which death occurred, and states that in some of them the anesthetic could not possibly have been responsible for the death. In others, exceptionally large doses were given. He has used it in 230 cases, and has been favorably impressed with its superior advantages. He mentions a number of minor points in the technic, and remarks that the sole disadvantage of the method is that the solutions used must be fresh every time. The Korff and Kummel technics are perfectly harmless, he thinks, and anyone can be sure of success by following their directions. Mishaps are due to disregard of the results of others' experience. There is no danger in using hyoscin (scopolamin) in small doses, and the small doses are equally as effective as the larger ones. He gives three-tenths of a milligram of hyoscin plus one milligram of morphin an hour and a half before the operation, following with .4 milligram of hyoscin plus 1 milligram of morphin half an hour before the operation. Early in the morning or the evening before the operation he gives a very small dose of some sedative to very excitable patients. Control tests with atropin-morphin given in 200 cases in the same way, he states, showed the superiority of the scopolamin-morphin technic. He always plugs the ears of the patient with cotton.

Penkert reports 140 gynecologic and obstetric cases, 94 of which were major operations, in which inhalation anesthesia was avoided by combining spinal anesthesia with the hypodermic injection of morphine and scopolamine. One

of the great objections to spinal anesthesia for all severe or protracted procedures has been the fact that the consciousness of the patient is not abrogated and that the mental suffering is therefore often very considerable. The author found that by giving 0.02 of morphine and 0.0006 of scopolamine in two injections an hour apart, the first one two and a half or three hours before the operation, the patients were reduced to such a state of apathy and somnolence that no recollection of subsequent proceedings was retained. The lumbar puncture and injection of the anesthetic solution were carried out as usual, the patient's face was covered, dark spectacles were put on and the ears were plugged with cotton. On awakening, it was found that not unpleasant memories were retained, that nausea was practically always absent, and that the bodily condition was stronger, so that fluids could be taken very early. The only disadvantage noted was the occurrence of headache in three cases.

#### CONCLUSIONS.

1. In the scopolamine-morphine combination, we have an anesthetic of apparent safety, if not used indiscriminately.

2. One dose of scopolamine 1-100 grain, morphine 1-6 grain, one hour before operation, supplemented by a few drams of ether, suffice to produce surgical anesthesia of at least two hours' duration.

3. There is practically no shock from even prolonged and very severe operations unless great quantities of blood are lost.

4. There is freedom from pain for many hours after operation so that patients often sleep all night after the most painful operations.

5. There is but trifling interference with peristalsis.

6. It lessens vomiting, tends to reduce shock and decreases danger on account of small quantities of ether.

## CAUTIONS.

1. The patient may sleep for many hours after operation; a fact which friends must be told of in advance.

2. Patient may be aroused at any time after operation, but should not be, as much excitement (even delirium) may follow.

3. It should not be administered to

patients under twelve years, nor to the very old.

4. If sleep is too prolonged, strong coffee may be given by rectum.

5. Where hemorrhage is feared, it should be used with extreme caution, on account of increased blood pressure.

6. It should not be used where chloroform or ether are counter-indicative.

## COMPLICATIONS OF ANAESTHESIA.

## THEIR RECOGNITION, PREVENTION AND TREATMENT.

BY F. D. BULLARD, A.M., M.D., PROFESSOR OF TOXICOLOGY IN THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

When that the surgeon cutteth, thou doest well in giving the vapors that put to sleep, for in so doing thou followest the example of the Lord; for in the book of Genesis it is written: "And the Lord caused a deep sleep to fall upon Adam, and he slept, and he took one of his ribs, and closed up the flesh instead thereof," but do not attempt, as did the Lord, to be both the anesthetist and the operator, lest in the closing up of the flesh the spirit of the patient depart from the body.

When that thou putteth to sleep, thou shalt take due care and observe with all diligence, the color, the pulse, the breathing, the pupil, and the relaxation of the muscles.

Thou shalt continually and carefully note the color of the face, more especially the angles of the mouth and nose, the hue of the cheek, the tip of the ears and the finger nails; and, if the color be of a natural fleshy tint or of a pinkish shade, then knowest that the heart of the patient beateth with strength and the lungs make pure the blood; but if the color of the cheeks becomes blue, the corners of the mouth a sickly pallor, the lips of a livid hue, the ears pale, or the fingers dusky, then

cease thou to give the anesthetic, lest the patient pass to that unknown bourne, whence no traveler ever returns.

Ever and alway thou shalt observe the beat of the pulse, that it goeth in regular steps as an army on parade, that it linger not too slow, lest its march be a dirge; that it gallop not too quick, lest its dance end in death; that it skips not as the lambs on the hill-side, or become so feeble that the grinding of the heart wane low, or the silver cord be loosed. And thy fingers shall be as the fingers of the blind, alert to read the story of the patient's condition, verily shalt thou keep thy brains in the tips of thy fingers, and in the ends of thy fingers shalt thou place watchful sentinels, that shall see danger when it is yet afar off. The learned touch of thy fingers should tell how high is the tension of the crimson tide, for this is the first to ebb, and, if the blood fail to reach the sleepless watchman of the breath of life, it may never flow again. When the breathing ceases, soon stops the flagging heart, and, when the stream of blood runs low, the wheel of life no longer turns. This is the most frequent and

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most pregnant with danger of all the complications of anesthesia. Especially if thou givest chloroform, shouldst thou know the vasomotor tone.

Nature herself doth make an antidote for the lowered tension, called adrephrin give thou it. Use it, but not in too concentrated a form, better ten minims in normal salt solution under the skin, or, if the emergency be great, direct into the veins. Bring low the head, that the heart may have whereall to beat upon, and that the breathing centers be nourished. Bring low the head, and force the breathing, that the great veins of the viscera be emptied of their useless floods. Bring low the head, that the fainting become not a fatal syncope, and, be there much blood lost, swell the failing tide with normal salt solution.

And be it that the angel of death threaten the patient, be not over alarmed, and, even though from fear thy flesh creepeth, thy voice sticketh in the throat, and thy hair standeth on end like the quills on the fretful porcupine, keep cool, and remember that thou alone art the pilot that can steer the sinking ship to the haven of safety.

And if the Angel of Death still knocks at the portal, force then the breathing with regular and slow cadence, pull out the tongue firmly and quickly, warm the body, lower the head, massage the heart, dilate the sphincter, give life-giving oxygen and use powerful drugs by the needle. And be not weary in well doing, but work thou patiently and long, for oft-times the seemingly dead will respond to thy efforts, the breath return as a zephyr, and the silent heart beat anew, long after thou hast ceased to hope for recovery.

When that thou givest an anesthetic, see that thy head goes not a whirling, and think not upon thy wife, nor upon thy neighbor's wife, nor upon thy successes, nor upon thy failures, nor upon the past, nor upon the future, but fix thy mind continually upon the duty that

lieth before thee. Look not on the operation at all—thou must know thy patient alone and him anesthetized.

And thou shalt observe the breath of life, how it goes; not quick, nor shallow, nor too slow.

As harkeneth the mariner in the dense fog for warning sounds, so shalt thou listen for signs of danger. Thou shalt be quick to know when the patient forgetteth to breathe; if the memory of breathing be but asleep, or if the centers of respiration be dead from poison. Thou must judge quickly and with inerrant judgment, for the scales of life and death are in thy hands.

And thou shalt watch the muscles of breathing, if they be set with Titanic strength, the blue lips, the bulging eye, the wide pupil, the blackened face, the fixed chest wall—all show the spasm which thou must overcome or else the struggle end in death.

Stand such a one not upon the head, for that maketh worse the trouble, but force the jaws apart, pull out the tongue, cease the anesthetic, then, if all be well, and thy patient breathe naturally, begin again, but slowly and with due care, and, if thou art still unable to put thy patient to sleep, stop, wait, and give him, ere a second trial, a quarter of a grain of morphine, if such be well bourne, with one hundred and twentieth of atropine. 'Tis better to admit a failure than to record a death.

Often the lagging jaw drops back, and sometimes a foreign substance, as blood or mucus, falls into the unprotected windpipe. Thou must ken such a state at once and, by thy own power or with the aid of others, remedy it without delay.

These four things may, while thou art still giving the vapors of sleep, stop thy patient's breathing—forgetfulness, spasm, foreign mass and paralysis—each must thou know, and for each the true remedy apply.

There are other and great dangers, that may come when thou art not near.

and cannot help. There are other and great dangers, that may come when thou art present, and cannot give help.

For ether maketh worse the lining of sick air tubes, injures diseased lungs, and may cause pneumonia or produce edema of the lungs. Then give not ether if the patient cough over much, and, if the sputa be like the foam of a beaten egg, cease at once, for this is a sign that the lungs are drowning in their own secretion and death is the end thereof. To such a one give atropine, draw the purple tide from the color-laden veins, dry cup the chest, give oxygen, but force not the respiration, else the serum be pumped into the bronchioles, and the air channels be thus clogged. In such a case, sometimes 'twere well to blister the chest walls; 'tis better that the skin should suffer, than that the lungs should die. Nitroglycerine and strychnine, and a moderate elevation of the foot of the bed, are also indicated. Beware then the water-logged lung, for it may develop early and be afraid of it, for it may begin later.

The best of all treatments is prevention, and watchfulness is her hand-maid.

To prevent pneumonia and bronchitis, crowd not the ether and give the vapor warmed. Have a thought to keep the inhaler clean, take due cognizance of the weather, and the prevalence of colds, if the weather be unseemly, if epidemics prevails, if the patient is prone to coughs, choose thou, unless greater dangers are present, chloroform.

Keep thou thy patient warm and dry during the operation, and see that thy patient go not from a warm operating-room to a cold chamber, else thou and the drug be blamed for that which other things may cause.

Bronchitis, pneumonia, edema—these three may be the sorry sequel of ether, but the worst of these is edema.

Give not ether to him that hath hard arteries or sick veins, for the vapor

thereof is vein-trying, causes the blood to bound in its courses, and maketh worse the lining of the sick urine tubes. Observe if thy patient hath albumen casts and hard arteries, take careful thought, and use little anesthetic, else the sewers of the system be clogged, and the patient die of his own poisons. That thou mayest lessen the amount of irritating vapors, give first morphia and atropia, and, if there be no fatty kidney, choose chloroform.

But remember that measure for measure, chloroform is more irritating than ether.

But know thou well that chloroform is like an enemy in the camp. As were the sons of Jacob to the children of Israel, so are the dangers of chloroform to those of ether, yea sixfold are the deaths of one more than the other. The less the peril from the knife, the more the danger from the chloroform. Soft as the zephyrs of morning, sweet as the incense of myrrh, the vapors of chloroform may be as dangerous as the typhoon of India, or the breath of the deadly Upas.

Before the soul hath lost its cunning, and after the mind hath found its sense, chloroform can muffle the drum beats of the heart forever.

Give not chloroform to him that is faint hearted, lest he die of fright, for fear is the father of many fatalities.

Remember that the heart is deceitful and uncertain in action, for it may cease, whilst thou art beginning.

Remember that the heart is deceitful and uncertain in action, for it may cease, when thou hast ended.

Give not chloroform to him that hath a weak heart, lest the anesthesia become an euthanasia, to him who hath a fatty heart, or to him who worships long and oft at the shrine of Nicotia, for great is the danger thereof, and the peril thereof cometh unheralded and quick.

Know when to say "thou shalt not

cut," for death followeth a knife used not in season.

Know when to say, "thou shalt cut," for death followeth not the knife used in season.

Know what to say, when asked for the faith that is in thee, and be able to assure, "It is well," and, if it be not well, thou make it well, or learn, that it cannot be made well.

If the trunks of great nerves be wounded, blow after blow falls upon the unheeding patient; 'tis well in such a case to benumb the nerves with cocaine, so that they will not transmit the insults. As continuous dropping wears away the stone, so frequent nerve shocks may kill. Look not on the operation lest thy attention be distracted.

Look on the operation, that thou may know if blood be lost, or if it be dark with danger, or if the nerves bear fatal messages to thy patient.

Give not chloroform in the sitting posture, else from lack of blood the breathing centers sleep, and the heart cease.

Give not chloroform to the struggling patient, or to him whose sphincters are being dilated, lest, in his deep breathing, the patient inhale over much of the poison.

Give not chloroform to him who hath large tonsils and adenoids, or who hath enlarged follicles at the base of the tongue, for such a one hath the Status Lymphaticus, and hath but little strength to resist, so the chloroform may overpower him.

From too much chloroform the heart may fail; from too little chloroform it may cease; from too great bleeding it may stop; from shock, from fear, from dyscrasia, from improper posture, from cessation of breathing, and from lowered vasomotor tone, it may succumb. Then watch thou, and remember, that eternal vigilance is the price of safety, and intelligent watchfulness the cost of success.

Crowd the chloroform not at all, but,

drop by drop, with eagle eye and active brain, with fear and trembling, use that drug, that more than wine can bite sharper than the adder, and sting more deadly than the viper. For like the scarlet woman of the byways, the smile of chloroform may deceive the unwary, and entrap the overconfident.

Like the scarlet woman of the byways, it may cause a deadly sickness, for it changes wholesome fibre to unhealthy fat. Long after its administration, it may cause a fatal degeneration of the ganglionic cells of the heart, of the heart muscles, of the cells of the viscera and of the glands, and of the coats of the blood vessels.

Give not chloroform to him that hath sick liver, for it causeth the skin to be yellow, and the eyes to be jaundiced.

Give not chloroform to him that hath a fatty kidney, lest it be made more feeble thereby.

Like a velvet-footed thief chloroform steals away the jewel of man's health, and leaves a bankrupt body to mourn its loss. Then give it not o'er much, or too often.

Give not ether to him who hath been a maniac, lest the demon again possess him, and the last days of that man be worse than the first.

Give not ether to the epileptic, lest he cry aloud and froth at the mouth.

Give not ether to the Bacchanal, lest he become riotous in his ravings, calm such first with the powerful morphine.

Crowd not the vapors on the conscious soul, lest he turn and rend thee, or thy reputation, for thy needless haste.

Crowd then the ether when the patient tries to spew, but take good care, that thou knowest that he be on the verge of vomiting, and not at the point of death. Turn the head to one side, that the wind-pipe be not filled with mucus. Keep the jaws and the tongue forward, lest they fall back, and choke the patient.

Ether causes a little nausea and vomiting frequently, but the spewing



from chloroform is more prolonged and dangerous.

The long and violent vomiting is due to the poisoning of the blood, and, if it be that the liver sickeneth at the same time, the danger therefrom is not little.

And the sickness thereof is like the sickness of the sea, that hath a thousand and one remedies, none of which may cure, but if thou washest from the stomach the poison-laden mucus, thou doest well.

'Tis better oftwhile for the after spewing, to give pellets of ice or sips of hot water, that the stomach be not full, and be at rest.

Allow not thy patient to vomit, while the surgeon cutteth. Ere vomiting occur, his pupils dilate, his heart beateth quick, and a pallor cometh about the mouth, but his eye winketh, if the cornea be touched; in such a case investigate quickly, judge aright, and crowd the vapors of sleep; but WATCH, WATCH, WATCH.

Watch with the eye of the hawk, the pupils of the patient, for they are the windows of the soul, and, when the spirit hath flown, the shutters are wide open. When the vapors of sleep are first inhaled, the frightened sentinels open wide the curtain; but, when the patient is sound asleep, they are drawn to; while, still later, if too much of the poison is inhaled, the windows are open wide, and there is none to answer to the call of light. Beware then, the dark and open pupil that is still; 'tis easy for the soul to slip by the drowsy sentinels, and death stand at the open door. Thou alone can bar his entrance.

Be fearful of the muscle that is lax, the jaw that lags, the arm that makes not protest 'gainst a fall, watch such a one, lest the strength of the man depart forever. Be watchful, and judge aright.

Watch the heart, for out of it cometh the blood, and in the blood if life; watch the breath, for it gaveth life to the blood; watch the color, for it tell-

eth of the life of the blood; watch the eye, for it telleth of the depth of the slumber; watch the muscle tension, for it measures the power of life to resist; watch these five things; and, if thou judgest rightly and quickly of their witness, the sleeper shall slumber safely in the keeping, and thou shalt not hear the jeers of the necromancers at thy failure, nor shall the worshipers of that, which in the stream of human progress, is but an eddy, exclaim to thee: "Thy patient is like to Asa the king, as it is written in the Book of Chronicles: 'And Asa in the thirty and ninth year of his reign, was diseased in his feet, and his disease was exceedingly great, yet in his disease, he sought not the Lord, but the physicians, and Asa slept with his fathers.'" Let thy patient sleep, but not with his fathers, then shalt thou reap the fruits of thy toil, and eat of the grapes of Esdraelon.

And this is the sum of the laws of the anesthetist: When that thou givest an anesthetic, give it as thou wouldst have it given unto thee, that the days of thy patient may be long in the land, that the Lord his God hath given him. Amen.

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*Cystitis.* A case may be diagnosed cystitis when pus is found in the urine in association with an inflamed area in the bladder. It may be inferred from such symptoms as pain and frequent micturition, and established by a direct visual examination of the interior of the bladder. Treatment: Rest in bed, a regular diet, tonics, baths, and due regulation of the bowels. Large quantities of bland water, citrate of potash for too acid urine and boric acid for alkaline urine.

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For *thirst in surgical operations* it will be well to remember Semmola's glycerine drink, which is often exceedingly grateful. It is one ounce glycerine and thirty grains citric acid to a pint of water.

## INAUGURAL ADDRESS

### AT THE OPENING OF THE TWENTY-SECOND ANNUAL SESSION OF COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

BY WM. D. BABCOCK, A.M., M.D., DEAN AND PROFESSOR OF DISEASES OF THE EAR, NOSE  
AND THROAT.

"Deep in each artist's soul some picture  
lies,  
That he will never paint for mortal  
eyes.  
And each author in his heart doth hold  
Some sad, sweet tale he will leave un-  
told."

We are glad to welcome you all to the twenty-second opening of our school. Before coming here you consulted with yourselves about what school you would attend and said to yourselves, "Shall I go to it because it is a small school?" Of course, our own crowd is always the blackest. It is ours; we love it. We think we have a good school. There are many things to be said in favor of the smaller colleges. In the last few years many prominent educators have strongly advocated the breaking up of the larger colleges into smaller ones. So prominent a man as Charles Francis Adams has advocated the dividing up of Harvard University into smaller colleges. It will, I believe, come sooner or later; that is, the day of larger colleges is numbered. In such schools as ours we are brought into close, direct contact with each one of you. We get to know you, what you need, just where you stand, and so can the more intelligently direct you. This fact was so clearly brought out that last year, even our janitor, Mr. Brewster, could tell about how each member of the Senior class stood. And let this be a hint to you: there are persons interested in your welfare that you little think of. If you look into the history of small colleges you will see that they have a much greater proportion of good, great men amongst their graduates than the larger schools do. See what this

little school has done in Los Angeles. Note the young men, note the good ones. The college does not make the man. It lies in himself to do it. He will forge ahead despite the school. The school only guides, directs, it cannot pour knowledge into him.

For a student to make a success in medicine he must "experience medicine," as our good preachers say about religion. He must "get possessed" with the desire to become a doctor. He must think of nothing else; dream of it; care for little else during his student days. I wish the new men and the old new men, the second year men, could get possessed with the knowledge that it is these two years that they either make or mar their future course. If they do, and devote themselves during the first two years to their studies, they will be a credit to themselves and to the College. It will make good, thorough men of you, and give our school such a reputation for turning out good men that you will glory in the fact that you were one of us. It has always been the desire of the faculty that vacancies as they occur, be filled by our own graduates. We have worked to this end and still propose to work on these lines until the majority of our faculty are our own graduates. We have the men now, in our present classes, who can, if they will, fit themselves so that they will be able to fill any or all of the chairs with honor to themselves and to the school. I am proud to say that the proportion of well-prepared students for the study of medicine, men with degrees, is larger in our School than most any other school in the country. The

policy of our School will be in the future, to do our weeding out the first two years. We feel that a student who cannot master these years is not fit to go on in the study of medicine. We want to send such men before the State Board of Examiners so that the State will have cause to look with pride upon our School. We have the best four classes that ever were in the School. You have amongst you men who can and will make their mark in the world. I want each one of you to take this as personal, meaning you, and say to yourself, "I am one of that number and will not fail him." If you do this, by the time the classes of 1906 and 1907 graduate, we will have made a name for our School that all eyes will be upon us, and it will be no trouble to raise an endowment for the School, as the faculty are now trying to do, that will place us at the head of the small schools in this section of the country financially.

As to the scholarship, "nothing succeeds like success." Let each one of you help us to raise the scholarship, and you can take the credit to yourselves of putting the College on a firm foundation, financially. Such success will attract wealthy people, who out of their abundance will give. They will not be attracted by a slow, plodding school. They want snap, energy, success. It will need individual effort. When we do get the endowment, we can raise the standard of the school faster than we are doing now. It is our intention each year to do this, working for quality, not quantity.

Of all special educations, that of science and the practice of medicine, when it is good, is the most exacting and makes the largest demands upon the staying powers of the student. It is longer, more confining, and requires more intense application than is required for a degree in either law or divinity. It also, from its nature, requires more outside, scientific reading. At his start in medicine, the student is brought into

close questioning relationship with that which he had thought of as one thing—a human being, a mystery, and now when he comes to put his hand on it to demolish, dissect, he finds a most wonderful and delicately-constructed machine. He is lost in the wonder of it. He sees the compact arrangement of the tissues, and like one who discovered a lost and buried city, notes the system of canals which carries the quickening fluid to the outermost ends of the drains, into which are cast the waste matter to be discharged without the walls. The white nerves send their branches into a net-work between the muscles under and over the canals and drains, and reveal to him the suggestion of a system of communication of intelligence and the issuance of orders to which the telegraphic services of the greatest city, have no comparison in relative extent and proportion. It is just these things that demonstrate the truth of and give foundation for a faith, which though usually silent, is sincere in a doctor. There is probably no one point in the career of the medical student so significant as that in which he first lifts the wet sheet from a body in the dissecting room. It is here that he either resolves or turns back. To those of you who are to make the first step, I want to say that just here you either strengthen or weaken your faith in a Creator. That there is one, I do not doubt; I may not call Him by the same name as you. I never saw the wonderful arrangement of the arterial system without standing in awe and realizing that there was and is an Infinite Power above and around us.

The impress made by the study of anatomy upon the truly thoughtful man can but be emphasized in the physiological laboratory, where the student learns the values and uses of the different parts of the human machine, and finds answers to questions which previous study of the silent body have evoked. Here, and in the associated laboratories, he



learns the chemical process of the body in health and disease, and the supplementary relationship of the different organs, the provision for their maintenance and repair, and comes to recognize and to know the function of the microscopic organisms, with which the body teems.

When the present conditions in medicine and the literature of the past are compared, we become aware of a great change in the conception of medicine. In former years it was speculation. Now it is investigation and experiment. Today there are no schools, no high authority, no hypothesis so firmly held that it is not instantly rejected when it fails to come up to the new knowledge. There is always the big question mark awaiting anything new in medicine. If it stands the question, it stays; if not, away with it. It goes into silence. We here, must prepare ourselves to question the new things. Be ready for all the new-comers.

In the history of the advanced knowledge of medicine, there are found two methods by which knowledge has been sought. In the one the endeavor has been made to form conceptions of objects studied by means of impressions conveyed on the senses. Experiment and investigation follows. The other is by speculation. In speculation the imagination runs riot, and as each philosopher gets an idea, a new system of medicine is started. Note Hippocrates and Galen, whose influence lasted for 1300 years. The decline in the medicine of Galen was due to the influence of the Church, although it nursed medicine and kept it alive. The Church regarded its dogma as sufficient, and checked all free inquiry.

Following Galen was Paracelsus, who overthrew the Galen system. Progress was rapid from this time on. To Francis Bacon of England, is due this large progress. He for the first time, showed clearly the methods by which knowledge must be sought, namely: that knowledge

increases by the observation of things and the proper interpretation of these observations.

Nowhere in the history of modern medicine can any one be found who can compare with Rudolf Virchow. He created the cell theory of disease. Unlike other systems, it does not pretend to be all-satisfying and all-explaining. Virchow has said that the introduction of the microscope has enabled us to approach several hundred times nearer to disease than before.

To the microscope is due the knowledge of the influence of bacteria in disease. They with the Koch methods of cultivation made our study of bacteria exact. The development of knowledge of the minute structure of the cells and tissues is principally due to the methods of staining, which started with the simple carmine stain of Gerlach.

In clinical medicine, the introduction of the clinical thermometer, the microscope, the methods of chemical investigation, the blood counter, Roentgen ray, have led to a closer insight into disease and have substituted knowledge for conjecture.

You must while here, perfect yourselves in all these methods of investigation, so that when you go out, you will be well disciplined and prepared to meet disease and the public. The public is getting better educated along scientific and medical lines. There has been in the past, too wide a separation between the public and the medical profession. The public has derived its medical information chiefly through newspapers, which information has been sensational and unreliable. Without correct information of the problems which face the medical profession and of the methods by which these problems are being solved, neither the sympathy nor the cooperation of the public may be secured. The general information in biology, human anatomy and physiology necessary for the application of medicine

is being imparted by the schools. Many of the popular magazines contain splendid articles on disease. The stories of such diseases as malaria and yellow fever have an actual fascination. The public is slowly, but none the less, surely, learning that disease is not a mysterious entity, dwelling like a devil in the body to be driven out by the use of some equally mysterious agent, but a condition of life which can be guarded against.

Science demands to know the methods by which knowledge can be obtained.

Every year sees the discovery of new methods. There should be, and with the foremost men there is, no distinction between the clinic and laboratory. I believe in the medical education of the future, where will be a restriction of laboratory training in anatomy, physiology and pathology—and an extension of training in the methods of the clinical laboratory.

## CLIMATE.\*

### IN RELATION TO DISORDERS OF METABOLISM AND THE CIRCULATION.

BY BOARDMAN REED, M.D., LOS ANGELES, CAL. LATE PROFESSOR OF DISEASES OF THE GASTRO-INTESTINAL TRACT, HYGIENE AND CLIMATOLOGY, MEDICAL DEPARTMENT, TEMPLE COLLEGE, PHILADELPHIA.

Climates in the recent past have been studied chiefly with regard to their effect upon tuberculous disease of the lungs. Their influence on the digestion, the metabolic processes, the heart and blood vessel system generally, and on the kidneys and excretion through the other emunctories, has been much less considered.

So much stress has been laid upon the influence of climate in tuberculosis that the laity, and some members of the profession, seem to have become imbued with the idea that no other form of treatment is necessary in that disease, and also that climatic treatment is of little use in non-tubercular affections.

In consequences of these impressions numerous tuberculous patients seek health resorts without definite instructions as to any special regimen or line of treatment to be followed, but, possessed of the false and dangerous notion that the air being all the remedy they need, they should avoid physicians and drugs, except the quack nostrums

which in their ignorance they deem safer than what they call "doctor's medicine;" and many victims of other chronic diseases, who would be helped by a change of climate, are not advised to avail themselves of this useful adjuvant even when they could well afford it.

It may be worth while, therefore, to call attention briefly to the following points:

1. A favorable climate, though important, is not so indispensable to the cure of pulmonary tuberculosis as is the maintenance of the circulation and of the blood-making and excretory organs in a state of the highest efficiency, together with full feeding, so that the nutrition may be improved to the utmost extent possible.

2. Climatic conditions may affect markedly not only the heart and circulation, but also the functional work of the blood-making and depurating organs, either favorably or unfavorably; e. g.,

(a.) Altitude, by its effect especially

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on the circulation and nervous system.

(b.) Temperature, by its effect on the circulation, appetite, digestion, hepatic function, and excretion through the skin and other emunctories.

(c.) Humidity, by its influence on excretion, especially through the skin, besides the tendency of excessive humidity combined with even a moderately low temperature to produce catarrhal inflammations of the mucous membranes both of the respiratory and gastrointestinal tract.

(d.) The relative purity of the air, including the proportion of oxygen and carbonic dioxide and the degree of contamination by various injurious gases as well as by dust and pathogenic germs, this climatic factor affecting powerfully the health in well-known ways as regards the blood-making processes in particular.

(e.) The amount of sunshine, by the stimulant action of the sun's rays upon various functions—directly upon those of the nervous system and indirectly upon others.

(f.) Wind, by its action upon excretion through the skin, kidneys and lungs.

(g.) The drinking water, by stimulating and often irritating the excretory organs, as well as other tissues in some cases, by its contained mineral ingredients, to say nothing of the organic impurities and other poisons that may be present in it.

3. A suitable change of climate can accomplish as much for many disorders of metabolism and the resulting diseases of the heart, arteries, kidneys, and skin, as it can for tuberculosis.

4. In ordering a change of climate for tuberculosis we should not overlook the probable influence of the proposed new environment upon the digestive, metabolic and excretory functions, since without a high degree of efficiency on the part of these, no consumptive ever gets well.

Most of the foregoing statements do not call for argument. They are self-evident. The evidence in support of the others is largely derived from the observations of the writer and of many practitioners who have had a still larger experience.

That even the best climates alone, without attention to the usual means of maintaining the highest possible nutrition, fail to cure numerous cases of tuberculosis that might recover with such help, will not be questioned by any competent authority.

Marked as is the favorable influence of certain climatic conditions in promoting recovery from both tuberculosis and many of the other diseases already mentioned, it is indisputable that they play a less important part in the care of most of them than does the best treatment by employing in so far as needed, all the means at our command, including diet and the appropriate mechanical measures, such as rest or exercise, or both of these properly dosed and regulated, hygienic procedures, and often electricity and massage in the metabolic faults especially. Yet it must be promised that the treatment needs to be carried out in a reasonably pure air, and never, if it can be avoided, in a large city or town. No patient can ever make the best progress in an atmosphere which is badly contaminated by the emanations of crowds of men or animals or by any other noxious effluvia.

It is common knowledge that high altitudes exaggerate heart troubles. It is equally true, though less generally known, that they in some not fully understood manner, affect injuriously the nervous system of some patients and indirectly impair their sleep, digestion and metabolism, thus lowering their nutrition. Any patient so affected at the higher elevations, whether or not infected with tuberculosis, will do better on a lower level.



Again, a moderately cold air as well as one containing the normal proportion of oxygen with an unusually small percentage of carbonic dioxide and other impurities—such an air as is found in both sparsely-inhabited mountains and seashore resorts—tends to stimulate the appetite and digestion.

So does sunshine unless accompanied by an enervating degree of heat.

On the other hand, when the cardiac force is weak and the arterioles are contracted by the products of a perverted metabolism, thus increasing the work of the enfeebled heart, cold aggravates the condition, while warmth of the air tends to overcome it and improve the circulation, thus promoting the metabolism and helping the nutrition.

It follows that while otherwise healthy persons affected with tuberculosis may do best in dry and cold mountain climates, provided they will stay out of doors in spite of the cold, cardiac and nephritic patients, as well as many nervous ones, even when tuberculous also, will progress more favorably nearer the sea level and in such a warm and comparatively dry climate as that in parts of Southern California.

The more chronic dyspeptics, as well as the aged, have generally a perverted or defective metabolism, and as a neces-

sary consequence their hearts, arteries and kidneys are open to suspicion if not already clearly diseased to some extent. Such patients will generally thrive best in a dry and moderately warm climate at not too high an altitude, where they can comfortably spend nearly all their time in the open air. Under these conditions with in addition a moderate amount of outdoor exercise, a suitable diet and an otherwise appropriate treatment addressed to the cause of the dyspepsia—its underlying pathologic lesion—even the worst dyspeptics often apparently recover and live out their expectancy.

Old persons, whether they have serious organic faults or only the slow degenerative changes inseparable from advanced age, require nearly always a mild climate and preferably a warm dry one at not too high an elevation, if they are to be comfortable and live as long as possible.

The milder dyspeptic and hepatic cases without senile changes or faults in the circulation or kidneys, may doubtless respond as well or better to the stimulating effect of the dry, cold air of our elevated western plateaus, provided always they are hardy or determined enough to live there out in the open a large part of the time.

916 Union Trust Building.

## NEOPLASMS OF THE OVARIES.\*

BY J. M. BURLEW, SANTA ANA, CAL.

It has seemed that a paper upon this subject is permissible on account of the frequency of neoplasms of the ovaries and the importance of an early diagnosis. We are all familiar with the many complications, as torsion of the pedicle, suppuration, gangrene, pressure symptoms, hemorrhage, intestinal obstruction, peritonitis, and obstruction to labor, that may follow such benign growths and the hopeless, helpless con-

dition of the poor unfortunate being upon whom a malignant growth has set its clutches.

Of the etiology we know very little. Of 36, 158 cases in Martin's clinic ovarian tumors were found in 1.4 per cent. They occur with about equal frequency between the ages of twenty and fifty years. The social state has no influence upon the development of ovarian tumors. They occur with about equal frequency

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in the single and married. Heredity is not believed to be a factor.

The classification of ovarian neoplasms is difficult and in many ways unsatisfactory, whatever method is adopted. The truth of this statement is shown by the fact that very few authors adopt the same classification. One may separate them into benign and malignant upon the basis of clinical manifestations; or as does the pathologist upon a histological basis. The pathologist's is no doubt the more scientific, but not the most useful for the clinician. A method of emphasizing the clinical manifestations with due recognition of the anatomical has seemed most helpful.

A. The *Benign Neoplasms* include:

1. Nonproliferating new growths.
  - a. Follicular cysts.
  - b. Cysts of the corpus luteum.
  - c. Tubo-ovarian cysts.
2. Proliferating new growths.
  - a. Pseudomucinous cysts.
    1. Simple
  - b. Serous cysts
    2. Adenomatous
    3. Papillary
  - c. Dermoid cysts.
3. Solid tumors.
  - a. Fibroma.
  - b. Fibromyoma.

B. The *Malignant Neoplasms* include:

1. Carcinoma.
  - a. Primary.
  - b. Secondary.
2. Sarcoma.
3. Endothelioma.

Follicular cysts are retention cystomata of the ripened Graffian follicle. It is very infrequent for a single cyst to reach a size greater than a walnut. Multiple cysts may form a mass the size of a man's fist. These cysts are probably the result of a previous inflammatory condition of the ovary which causes a thickening of the tunic preventing rupture of the follicles.

Cysts of the Corpus Luteum are retention cystomata of the ruptured Graffian follicle. They are usually solitary

and not of greater size than a walnut, but they have been reported as being the size of a child's head. They are characterized by rather thick walls, the inner lining of which is arranged in folds and is of a yellow-orange or brown color. The contents is a thick, syrupy, ropy fluid, red brown, yellow or resembling pus and containing or composed of degenerated blood. Like the follicular cyst they probably arise from chronic hyperaemia or inflammation.

Tubo-ovarian cysts involve both the tube and ovary. Their formation is explained by adhesions taking place between a pathological tube or ovary, the dividing septum later becoming absorbed to a greater or less degree. They are usually unilateral and do not as a rule reach a size greater than a man's fist.

In enumerating the proliferating new growths we first mentioned the pseudomucinous cyst. This is also known as cystadenoma, glandular proliferating cystoma, cystadenoma pseudomucip. Pfannenstiel chooses to call it pseudomucinous from its contents, a thick turbid, often colloid material varying in color as gray, yellow or greenish, due to the presence of cholesterin; cloudy, opaque or flocculent from an admixture of cells; red or brown from blood. It has a definite chemical composition.

This is the most frequent form of ovarian cyst. It is a pedunculated multilocular cystoma, lined with cylindric epithelial cells which secrete the pseudomucin. In 95 per cent. of the cases it is unilateral. Its growth is unlimited. The largest on record is reported by Cartledge; the cyst and contents weighed 245 pounds.

The external surface is smooth, pearly white or bluish. Through rupture of a pseudomucinous cyst metastatic or implantation growths with cystic and pseudomucinous formation may occur in the subperitoneal tissue or as implantation of pseudomucinous masses upon the

peritoneum with chronic peritonitis. The etiology is not known.

Simple Serous Cysts, so named from their contents by Pfannenstiel, are found as pedunculated, rarely interligamentous, tumors varying in size from an apple to a child's head. In external appearance they very closely resemble pseudomucinous cysts.

They are lined by a single layer of normal proliferated cylindric epithelium, which secretes the serous fluid contents. They are usually unilocular. The contents is a more or less clear serous fluid, yellowish or green, or when blood is present, reddish brown, and resembles blood serum, chemically and physically. It is a slow growing tumor. Growth may be arrested with absorption of the serous contents. Rupture may occur with absorption of the fluid and atrophy of the tumor but usually the sac refills.

Serous cystadenoma is a rare form of ovarian cystoma. It is a pedunculated, multilocular, usually unilateral tumor of slow growth and usually small size. It is lined with ciliated columnar epithelium which secrete a serous fluid, rich in albumen but containing no pseudomucin.

Papillary cysts of the ovary are by many authorities thought to be secondary to serous cystadenomata, the papillary growths developing either upon the surface of the cyst or within the cystic cavity through the wall of which they may grow or cause rupture by pressure. They may develop as subperitoneal growths, usually in the broad ligament or as pedunculated extra-peritoneal tumors, or as warty growths covering the ovary. The contents are of a serous character, pseudomucin being found only in the slightest trace, if at all. The epithelial cells are of the columnar ciliated form. The papillary growths may become implanted upon the pelvic peritoneum or the peritoneum throughout the abdominal cavity through separation of a surface papillomata or those set free by

the rupture of a loculus. Such implantation through excessive proliferation may fill the abdominal cavity causing ascites and usually resulting in death from exhaustion. Regressive changes have occurred after the surgical removal of the primary growth.

Dermoid cysts, as the name implies are cystic tumors containing skin structures. They are thought to be rudimentary embryo, which have developed from the ovule within the ovarian follicle. They are the least frequent of ovarian cysts, usually small, seldom reaching a greater size than a man's head and commonly unilateral. The contents vary in consistency, containing often a fatty substance, balls of or loose hairs, teeth and bone. They may be combined with pseudomucinous cysts, rarely with serous.

Teratoma is a tumor closely related to dermoid. It contains formed organs, such as mammary glands, thyroid gland, brain. It is usually a solid tumor. It is rare. A dermoid which takes on this atypical modification is an extremely malignant growth, being destructive and scattered by metastasis and implantation.

Of the solid tumors, fibroma and fibromyoma are all that need be considered. Fibroma consists of interlacing connective tissue, forming a diffuse hyperplasia of the entire ovarian stroma. Unstriated muscle fibre added to the above constitutes the fibromyoma. These tumors are usually pedunculated, hard in consistency, surface smooth or slightly nodular, varying in size from a walnut to that of a man's head.

Any of the proliferating new growths may undergo malignant degeneration, carcinoma being much more frequent than sarcoma.

The malignant growths of the ovaries, as was stated, are carcinoma, sarcoma and endothelioma.

Carcinoma may be primary or secondary. Secondary carcinoma is rare.



The literature upon primary carcinoma is limited. It is found as a cystocarcinoma, less frequently as a solid tumor. It is found at any age, most frequently between the ages of thirty and fifty years. The growth is usually bilateral, but not necessarily developed at the same period. The solid carcinomata are medullary or scirrhus. The medullary form are ovoid or globular growths. The surface is white or yellow and slightly nodular. In size they are rarely greater than a foetal head. Scirrhus carcinomata have a smooth surface, are not larger than a man's fist and occur at an advanced age. Metastasis of the solid carcinomata follows the lymphatics, first involving the retro-peritoneal glands.

Cystocarcinomata have the shape and consistency of pseudicinous cysts, but are smaller, rarely larger than a foetal head. They are multilocular containing a clear or cloudy serous fluid; this may resemble pus through a mixture of cells or blood from blood. The walls contain thickened areas of medullary carcinomatous nodules, some being visible to the eye, others only by the microscope. The walls are lined in places with a single layer of epithelial cells, in other places by many layers of atypical proliferating epithelial cells. Metastasis first extends to the pelvic peritoneum but may gradually invade the whole abdominal cavity, studding the peritoneal surfaces with delicate cysts, a reproduction of the primary growth. Metastasis is relatively slow. This is soon followed by ascites, cachexia and death.

Sarcoma is a tumor of variable size, sometimes as large as a man's head and usually attached by a short pedicle. It may occur at any age but most frequently between twenty and thirty years. The shape is round or cylindrical, and surface, smooth, rarely irregular and nodular. It may be either of the spindle cell or round cell variety. The spindle cell is of a dense consistency resembling

fibroma, but may be differentiated from it by the irregular coloring of the tissue. The round cell variety is softer in consistency. Each microscopically shows the characteristics of sarcoma. The round cell sarcoma is often found bilaterally, and is the form of childhood. Round cell sarcoma is very malignant, the spindle cell sarcoma less so. Of the malignant tumors of the ovaries, sarcoma furnishes ten per cent. Secondary sarcoma is rare.

Endothelioma is not an exceedingly rare form of tumor of the ovary. It has its origin either in the blood or lymph vessels. It may be unilateral or bilateral, hard or soft, solid or partially cystic. Its surface may be smooth or nodular. It is identified through microscopic examination.

Cysts of the parovarium, while not cysts of the ovary proper, should be mentioned in connection with ovarian cysts. Clinically they cannot be differentiated. Parovarium cysts develop from a cystic dilation of the tubules of the parovarium. They are usually unilocular and develop between the peritoneal layers of the mesoappendix the tube and ovary or ovarian and tubo-ovarian ligaments. The ovary is unaffected by this growth.

So lengthy a classification may seem tedious and impractical. To attempt to place in its proper class every ovarian cyst of which a diagnosis is made would be most impractical, a waste of energy, and of time, but it is of great importance to establish with some degree of accuracy whether a tumor is benign or malignant. This requires a definite, accurate outline of the various neoplasms, which reviewed before the mind's eye, at once reveals the possibilities of the condition. For personal reasons of more or less importance to the patient, delay often is asked. What our council shall be must be governed by a judgment based upon the clinical manifestations characteristic of each class of tumors.

To determine the malignancy of a tumor is unfortunately not an easy task. An exploratory laparotomy and even the assistance of the microscope will often be required. In drawing conclusions a few general principles may be applied to ovarian neoplasms as a whole. Solid tumors are the more likely to be malignant. Pedunculated tumors are usually benign, the important exception being sarcoma. Bilateral tumors are most frequently malignant. Early adhesions and immobility, rapid growth or slow growth taking on rapid growth, speak for malignancy. Ascites more frequently accompanies malignant than benign ovarian tumors. Dilated pulsating vessels in the region of such tumors suggest malignancy. According to Stander about 20 per cent. of all ovarian neoplasms are malignant.

In the diagnosis of ovarian neoplasms there is little in the history or symptoms that is of direct value. Indirectly this is important for symptoms not pointing to a definite organ as the seat of trouble but making up an indeterminate group of aches and pains and disturbances of the nervous system, may furnish a clue to ovarian trouble. Any abnormality in the position of the uterus or the pelvic floor should direct attention to the ovaries before dismissing the trouble as due to other causes. Menstrual disturbances are suggestive. The diagnosis of ovarian neoplasms must therefore depend upon physical signs. The smaller growths can only be recognized by bimanual palpation. I would emphasize the important information that may often be had by rectal palpation. Systematic examination will often reveal ovarian neoplasms that would otherwise escape notice for many months. When the growths have reached a greater size the diagnosis is chiefly differential. To review the conditions with which ovarian neoplasms are most frequently confounded will suggest to each of you the differential

points. We are most frequently called upon to rule out pregnancy, distended bladder; abscesses, especially appendicial; cyst tumor of the kidneys, encysted ascites; phantom tumor; fat in the abdominal wall; tumors of the uterus and free ascites.

Having established the diagnosis the treatment is immediate ovariectomy. All attempts to cure these growths or arrest their development by other means, such as medicines, manipulations or electricity can avail nothing and in many instances are of positive damage. Reed in his summary says, "It may be stated as a rule to which there are no exceptions, that ovarian growths, either by virtue of their primary characteristics or in consequence of secondary changes, tend to the death of the patient." There is much less danger in the removal of a small pelvic growth than one which has exhausted the patient and formed adhesions to the surrounding viscera.

To delay is to invite complications with the great train of mishaps and dangers which accompany them; to bid for malignant degeneration or metastasis with almost inevitable death. Delay is only justifiable when the condition of the patient does not warrant an operation and then should not be prolonged over a greater period than is required to improve the condition so that operation may be safely undertaken.

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#### DISCUSSION OF DR. BURLEW'S PAPER.

DR. W. W. BECKETT, Los Angeles:—A small tumor in a large fleshy person is hard to diagnose. Malignancy was generally impossible to foretell. This mattered little as all tumors ought to be removed, for many benign tumors later become malignant. In cystic tumor, peritoneal cavity was not to be soiled by escaping fluid. Dermoids he had not found to be very malignant. Hard tumors more in tuberculous persons. Cited several cases of this type. In doubtful cases, an exploratory incision was indicated. Only in large cystic tumors with pressure on heart, was tapping prior to operation advisable. Age was no contra-indication to operation. In removing a tumor of ovary, always satisfy yourself as to position of sound ovary. New tumor may appear in sound ovary later. Cited a case.

## SANITARY INSPECTION\*

### AS APPLIED TO WATER COURSES.

BY J. L. CHOATE, A.B., STUDENT IN CLASS OF 1909, COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA, FORMERLY INSPECTOR OF WATER COURSES AND CALIFORNIA PUBLIC HEALTH DEPARTMENT ASSISTANT.

Probably our bacteriologists will not agree that the bacteriological examination of a water as a test for its utility for a community is of little value; but we can no longer say that, because upon the examination of a water we have found no pathogenic organisms, that the water is pure or good for the use of a community. The great limitations imposed upon us by the technique of the bacteriological laboratory makes it possible to examine but a very small amount of water; an amount so small as to be almost infinitesimal, when compared to the great bulk of a stream or large reservoir.

In considering the utility of a water supply for the use of a given community the citizens of that community are going to look at its possibilities from widely different standpoints. One class will consider it wholly from a commercial point of view, and will look at it only from its relation to the commercial interests of the community concerned. Another, more intellectually trained, will ask as to the purity of the water, and whether it has been examined chemically and bacteriologically, and if so, and there have been found no harmful organisms, this class will pronounce it good. A third class and by far the largest of those, who consider the water, will do so wholly from an aesthetic standpoint—and this is not to be underestimated.

It is a well known fact among medical men that the majority of people drink too little water, so we should not pass by as trivial, any encouragement we can give along this line. For decades people have spent their vacations at watering

places and have been benefited—not so much from any therapeutic value connected with the water as from the amount drunk. California possesses watering places with springs that rival those of Manito or the great Schlangenbad—"Beauty Springs"—of Germany or the Vichy of France, yet they are not widely patronized nor is the water drunk so much, because the surroundings are not so pleasing—do not satisfy this aesthetic side of our nature.

It has been customary in our cities to make, from time to time, careful bacteriological examination of the water used. This is well so far as it goes and should not be discouraged, but we must go farther than this laboratory examination of the water, in order to say that it is sufficiently pure to be used as drinking water for a community. As we know it is impossible to examine but a very minute particle as compared to the volume of water in a stream or reservoir of sufficient size to supply a city with water, and although there may be millions of harmful even pathogenic bacteria in the water we are not apt to be so fortunate as to get even a single one in the small amount we are examining. So it becomes necessary that we resort to some other method to go side by side with our laboratory work.

We have on record hundreds of cases of pollution of streams by typhoid, and other similar germs, with resulting epidemics following these pollutions; but in none or scarcely none of these cases have they found by bacteriological examination a single *Bacillus Typhosus* in the many samples of water examined. So many records have been kept of these

\*Written for the Southern California Practitioner.



epidemics of water borne diseases that their cause is no longer a mere hypothesis, but a fact established by abundance of evidence.

The problem of working out all the conditions surrounding such an epidemic is no longer of vital importance. Although the cause of the epidemic must be obtained in this way, still like the post-mortem examination, it is only of preliminary importance in helping us to attack the greater object in view—that of the prevention of the evil.

What is meant by sanitary field inspection is the working out of the conditions of a community and so arranging the facts obtained, that they may be of value in case of the outbreak of an epidemic, or perhaps, be the means of the prevention of such. In looking over the histories of epidemics, especially those of water born diseases, we see even in cases of large mortality, how simple their check would have been if only their cause could have been obtained earlier. So it becomes the duty of the inspector to set before the health officer, in the form of maps, charts and tables, the conditions of his community, so it will become easier for him to grasp at once the source of the trouble.

In the case of all epidemics such an inspection becomes necessary and the time for it is before and not after the outbreak. Such an investigation necessarily requires a great amount of time and it is a crime against the community to take this time at the expense of lives when it could and should have been done before.

You may ask, what is meant by sanitary inspection? Does not the health officer of the community make an inspection of his territory every time he makes his rounds?

A thorough inspection cannot be made by driving along the high-ways or by visiting the few dairies that may be in the health officer's territory. To make a thorough investigation one must know his territory so well that he is able to

put on his map and charts points of topography even more in detail than are given on the U. S. Topography sheets. And for one to be able to make such a map shows whether he has really covered the ground as should be done. But a map showing topography, drainage and so on, even though in the most minute detail may by no means cover all the features.

A sanitary map must not only show the relation of streams, drainage areas, etc., but also the relation of the inhabitants to one another—and this is by far the harder part of the task.

In a recent personal investigation of the sanitary conditions of a northern district, a valley but some eighteen miles long by three miles wide—but an investigation which took over three weeks of actual work in the field—the larger part of the time was spent in studying the relation of the people and not of streams. It was found early in the investigation that a number of cases of typhoid fever had occurred throughout the valley that fall, and that a few cases had occurred the year before. We at once went to the health officer in charge to learn what we could of the cases. He had just returned from the field and had left orders for all excreta to be buried or burned, and had investigated the cause and believed that it came from filth—the hog pen being too close to the well at the place where the first cases occurred.

Of course it is entirely possible for germs of typhoid fever to be carried by hogs and so pollute a well, but in this case it was hardly probable and upon further investigation it was found that the cases had a direct relation to a previous epidemic in a neighboring district.

The health officer's orders to the patient's family were not correctly carried out, for instead of burying the excreta it was carried some hundred yards back of the house and thrown on the bank of a stream which but a few miles below was

to be used by a community of hundreds of people. The report showed also the possible pollution of the stream by two other cases, pollutions which could never have been known only through a careful and detailed inspection. These places of pollution were emphasized in the report and their location marked in red ink on the map, so that when several months later a few cases of typhoid occurred a few miles down stream among persons drinking the water, attention was at once turned to the water supply and a possible epidemic checked.

The inspector who does this kind of work should not take it to be his duty to institute reforms. If he attempts to do so he will very soon become so unpopular that he will find it impossible to successfully carry on the work he has before him. Even among the more en-

lightened class, will be an utter lack of appreciation of sanitary laws and people will drink water from streams which but a short distance above, act as sewers for the entire community. It is not uncommon to find people drinking water from a stream which through its filth alone has become uninhabitable to the fish. Even among the more substantial country homes it is not uncommon to find the sewer or cess-pool over-flow turned up-stream rather than below the well. So rather than for one to attempt reforms and thereby soon find himself swamped in a hopeless task, it is best to devote one's energies to the study of conditions as they exist, in the hope that they may serve the public later. At the same time never failing, if where it will be appreciated, to drop a suggestion for betterment of sanitary conditions.

## DEPARTMENT OF DISEASES OF WOMEN AND CHILDREN.

WILLIAM A. EDWARDS, M. D., EDITOR.

### EDITORIAL COMMENT.

**The Necessary Requirements for Intelligent Infant Feeding.**—The feeding of sick infants or children is a much more difficult problem than that for the healthy babe or growing child. It requires much more than memory to adapt diets to sick children for therapeutic reasons.

The rules for the adaptation are of course the same, but the judgment required to properly combine the constituents is the all-important matter. If, for example, a sick baby of six months of age is suffering from proteid indigestion and demands 1.5 per cent. of fat and only 0.5 per cent. of proteids with the sugar at 5 per cent., we would proceed thus: You will note that the fat is three times the proteids, therefore use 12 per cent. top milk, for convenience in making the calculation. The babe will receive seven feedings of 7 ounces each, or 49 ounces; our for-

mula is therefore  $1\frac{1}{2}\% \times 49 = 6\frac{1}{4}$  ounces of top milk added to 42 $\frac{7}{8}$  ounces of the diluent. We must add 5 per cent. of milk sugar to the 42 $\frac{7}{8}$  ounces of water, the diluent. This will amount to about eighteen teaspoonfuls of milk sugar.

Sometimes the so-called infant foods are very useful in combination with cow's milk for a short period during a dyspeptic attack in infancy or childhood.

These same infant foods have been the cause of much controversy and not a little ill feeling between the physician and manufacturer. Of course the physician maintains that, as a rule, a child cannot be raised on an exclusive diet of prepared infant foods. But they have their place and when intelligently used are often very useful, in a limited number of cases. In fact sometimes the combination of infant foods and cow's milk seems to be the only one for certain children.

The principal objection to their use is that they are dried, heated substances, not always fresh and in most cases they are dangerous for prolonged use, and always unsuitable unless combined with fresh food, as cow's milk.

The foods come under three classes: Dried milk; a cereal in combination with milk or alone; or a malt preparation added to one or other of the above. Many of these are nothing but a dry cereal and cannot be used for any length of time without producing symptoms of either rickets or scurvy. All infant foods are only to be employed by one skilled in infantile dietaries and they are always to be added to fresh food—cow's milk.

They all are apt to contain some sugar; the most objectionable as an exclusive diet for infants are those which contain dried milk, a cereal and sugar. The least objectionable are those which contain some form of malted carbohydrate, a desiccated malt extract and a diastase. This in combination with cow's milk is often a happy expedient for a short time.

Another class contains only carefully prepared cereals and is often useful when for a time we wish to place the child on a "no milk" diet. All prepared infant foods, including condensed milk, have a deficiency of fats and an excess of carbohydrates. The proteids of cow's milk heated and dried are the most indigestible foods that we can possibly give to an infant. Condensed milk with its high sugar content may cause acid indigestion. The market contains this milk prepared without sugar. The infant foods find their best application at or after the period of weaning. Here cereals added to the milk serve a double purpose, they aid nutrition and they assist in breaking up the large amount of casein, which at this time is given in amounts four times in excess of that in mother's milk.

An infant suffering from casein indigestion with colic is much relieved by adding a cereal or a malted food. By the latter we also add malt sugar to the dietary, a valuable, easily-digested carbohydrate. The infant will often speedily increase in weight under its use. An atrophic infant who does not gain on a milk diet, will often do well on a combination of starchy cereals, malted foods and milk. These infants may take large quantities of carbohydrates and flour and do very well on them. This we can only determine by trying each individual case.

As examples of the three groups of infant foods we may cite: Horlick's, Carnrick's and Nestle's foods as in group one, containing dried cow's milk, some cereal and sugar. Group two is represented by Mellin's food, that is a malted carbohydrate; some of these foods contain diastase. The third group is made up of pure, carefully-prepared cereals as represented by Imperial Granum or Robinson's Barley.

Some new-born babes when placed on a percentage mixture that seems to us to be correct will not do well, in spite of frequent modification of our mixture. They will have almost constant colic, green movements mixed with curds, will sleep little and fail to gain in weight. Keating and myself place these children for a short time on peptonized milk by the cold process, to avoid giving the milk a disagreeable taste. We use only a portion of the tube and add it to the milk a few minutes before it is to be taken. It is shaken well and heated for two minutes. After a few feedings of this kind the child will show marked improvement. In other cases we may use the whey modification of cow's milk as suggested by Rotch.

Whey is made by adding a tablespoonful of rennet to a quart of milk, mixing and allowing it to stand until the separation of curd and liquid occurs. The



curd is broken up thoroughly and the whole is strained through a cheese cloth. About 20 ounces of whey will be thus produced. We cannot mix whey with either milk or cream, until the rennin is destroyed. This may be done by pasteurizing it, that is, heating it to 165 degrees Fahrenheit, for thirty minutes; better not boil it. Whey contains the liquid proteid substances of milk, lactalbumin and lactoprotein, with salts and water, and is most useful in feeding infants with intestinal catarrh. It will nourish a child for several days and in many instances we prefer it to albumin water which is so popular, but which may develop the dangerous toxin-cholin.

For infants who are unable to digest the usual modified cow's milk, whey is a very valuable means of getting over the difficulty.

When cow's cream and milk is modified to assume the proportions of mother's milk we still unfortunately have a casein which is not in the same relative proportion to lactalbumin as in mother's milk. If we make a whey thus separating the liquid proteids from the casein, and recombine them, the similarity to mother's milk is much more absolute.

Human milk contains two-sixths of caseinogen and four-sixths of lactalbumin and lactoglobulin, whereas cow's milk is four-sixths of casein to one-sixth of lactalbumin and lactoglobulin; but in whey we obtain all the absorbable proteids. Therefore if we use highly-concentrated cream and skimmed milk for the caseinogen, with whey we have relatively and actually the same proportions of caseinogen, lactalbumin and lactoglobulin as in mother's milk. Unfortunately the modification of milk by whey is a difficult matter to carry out at home and demands laboratory preparation which in many instances is prohibitory. It is a very difficult mixture to prepare but it is perfectly ideal when properly done.

It is only to be used for a short time, however, as it is a fact that children fed on these very carefully and very scientifically correct mixtures do not do as well as those fed in the more usual way.

Another method that has been most successful in our experience in combating difficult proteid digestion is the use of barley gruel. It may be used for a new-born infant and is very valuable also from the third month on to the later periods of infancy. The addition of a barley gruel to a milk mixture undoubtedly adds to the digestibility and the assimilation of the curd.

If you will observe the curd that all infants spit up from time to time you will note that the barley combination has a finely divided curd not unlike that from mother's milk.

We prepare the barley gruel in a manner that Koplik has also found to be very helpful. A heaping teaspoonful of Robinson's Patent Barley to the pint of water, dissolve and stir over a concentrated heat, until it boils, keep it boiling for fully fifteen minutes to prevent sugar precipitation. While boiling the required amount of milk sugar is added, allow to cool and add top milk to the proper percentage quantity.

The addition of dextrinized gruels is advised by some for both the healthy and sick infant.

Dextrinized gruel is a thin barley or flour gruel dextrinized by adding diastase, and this in turn is added to the milk; we, however, rarely use it for healthy children unless all other methods of milk feeding fail, but for sick infants or children it is a most valuable proceeding, particularly those of the marantic type in which the marasmus persists in spite of all other methods of feeding.

The methods of preparation of Chapin and Kellar are those generally accepted by all of us. The former adds a tablespoonful of flour to one and one-half

pints of water and boils for fifteen minutes. Then add a teaspoonful of a solution of diastase. The mixture will become thin and is then dextrinized. It is thus used as a diluent with the milk in a proper percentage mixture. Kellar uses a Liebig formula malt extract, to which he adds potassium carbonate as an animal salt. One hundred grams of this is added to five hundred C. C. of water and dissolved. Then another preparation is made by suspending fifty grams of flour in five hundred C. C. of milk, making a smooth uniform solution. This is then strained through cheese-cloth. The first solution of malt extract and the second of milk and flour are mixed together, put into a vessel and stirred constantly over a slow fire. After twenty minutes of slow heating and stirring the mixture is allowed to boil to check digestion. It is then placed in six-ounce bottles, corked and cooled. The mixture is easily assimilable and seems to have a happy effect upon casein coagulation, containing as it does, a dextrinized cereal and malt sugar, as the starches are converted into sugar by the malt extract.

Every marantic baby, or those suffering from infantile atrophy, chronic or subacute enteric catarrh, or those whose weight remains stationary, should, if other methods of milk feeding fail, be given this dextrinized gruel combination and in many instances the results will be startlingly satisfactory.

When feeding these thoroughly cooked foods to infants we must ever be alert to detect symptoms of scurvy. After the marantic infant has received this food for two or three weeks and is thriving we must add fruit juices to the dietary, and as soon as the body weight reaches a point that is normal for the child's age, we had better return to a milk diet, raw milk if possible, but the return must be cautiously made. It is perhaps not safe to feed a baby

dextrinized gruels made with the Chapin or Kellar formula for longer than three months. They will then cease to gain weight and become anaemic or perhaps scorbutic.

In feeding all sick infants and children there are two points that must never be forgotten. They are: The child will either take too much or too little nourishment, if left to itself without intelligent supervision. The mother is apt to overfeed her sick baby, and the marantic child will often take immoderate quantities of food, unless it is controlled. Finally we must consider the feeding of premature infants or those who are constitutionally or congenitally weak.

Of course the ideal way to feed a weak child is with breast milk, but these weak infants have a very poor suction power and sometimes the congenitally weak or the premature infant is unable to nurse at all. Then we must pump the milk from the breast and feed with a Breck feeder. Sometimes even then the babe will be unable to nurse from the feeder and we must feed it by gavage four or five times in twenty-four hours. We must remember, however, that if the premature infant is born much before term the mother's breast will contain but little if any milk. Then always obtain a wet nurse, with uniform milk and whose baby is one or two months old. If we cannot obtain a wet nurse we must place the baby on modified cow's milk, with low proteids and low fats until the milk appears in the mother's breast. Remember to have the initial fat and proteids low or we will set on foot digestive disturbances that will be hard to control and that may threaten the life of the little infant.

Remember also that with the premature infant, or the congenitally weak infant, the mother's milk will decrease in quantity from lack of the stimulation of the vigorous baby. We must

therefore supply a healthy baby to nurse also, and supply the vigorous sucking which will keep the mammary glands active, otherwise the glands will finally cease to secrete.

#### REVIEW OF THE LITERATURE.

**Gonococcus Ophthalmia.**—It was shown at the New York Academy of Medicine last March that gonococcus vaginitis in children is a very frequent disease among all classes, extremely intractable in its course, highly contagious, requiring rigid quarantine of affected children as well as nurses and attendants, and in some forms capable of being dangerous to life on account of possible acute gonococcus pyemia. Previous to the appearance of the papers read at this meeting there had appeared, during the last few years, a number of others dealing with this same subject and emphasizing the remarkable frequency of this disease in children.

It is probable that the affection existed in quite as large a number of cases in years past, and that the increase, in frequency is more apparent than real, due to the greater care which is now taken to exclude all forms of contagious disease from hospitals and the consequent resort to microscopical examination of the smear made from the vaginal secretion or discharge. Such an investigation is now undertaken in every suspicious case; and in the children's wards of most hospitals it forms a regular part of the physical examination of every applicant for admission—certainly a more exact means of diagnosis than when the clinical picture alone was depended upon.

Notwithstanding the apparently greater prevalence of this vaginal infection in children, there has been no increase of gonococcus ophthalmia, either in the newborn, in children, or in adults. This is proven by the experience of ophthalmologists in general, and borne out by statistics obtained

from the annual reports of the various eye hospitals and clinics. On the contrary, there has been a decided diminution in the number of cases of gonococcus conjunctivitis. The writer gathered the reports of all such affections occurring among the patients of three large eye clinics of this city during the period of 1899 to 1894, and compared these with those reported during an equally lengthy period extending from 1900 to 1904. During the first five years, the proportion of cases of ophthalmia neonatorum to all conjunctival affections was about 1:100 and of gonorrheal (adult) ophthalmia about 1:200; during the latter period of five years, the proportions were about 1:500 and 1:650, respectively. This reduction of frequency must be all the greater in resort to microscopical examination of the smear of the conjunctival secretion is now more frequently done, so that mild cases rarely escape detection.

Credé's method of prophylaxis has most to do with the reduction in the frequency of ophthalmia neonatorum. The law compelling the reporting of all cases in which there is any suspicion of conjunctivitis has also had its good effects.

In the great majority of cases of gonococcus ophthalmia, whether the infection be mild or severe, the prognosis is good, provided proper treatment is instituted sufficiently early—before the process has invaded the cornea. In infants the general bodily condition must be considered. The prognosis is better in healthy than in feeble infants. The introduction of the organic silver salts, such as protargol, argyrol, and the like, has given us the means of destroying the gonococci without causing the pain and irritation which accompanies the use of solutions of nitrate of silver. The Germans however still think that the nitrate of silver is more reliable.

This difference of opinion regarding



the relative merits of the organic salts and of nitrate of silver applies not only to their uses during the course of a gonococcus conjunctivitis, but exists particularly in connection with the employment of these remedies as prophylactic agents for the prevention of ophthalmia neonatorum, particularly in hospital practice.

For many years the writer watched the effects of instillations of solutions of protargol (25 per cent.) into the eyes of the newborn, compared these with the results obtained when a 2 per cent. solution of silver nitrate was used, and came to the conclusion that, in hospital practice at least, the silver nitrate solution was the more reliable as a prophylactic agent.

Regarding a preference for one or the other of these two classes of silver preparations in the treatment of gonococcus conjunctivitis, the differences of opinion may be explained by a failure to consider the indications for each.

The organic salts of silver are indicated in the early stage of the conjunctivitis, which period is marked by the occurrence of a profuse discharge; and the particular use which they subserve is the destruction of the gonococci. Experiments show that this germicidal action is just as efficient as with silver nitrate, equally penetrating, and accompanied with no irritation or pain; hence such remedies can be used much more liberally and much more frequently than the nitrate. To be efficient, however, the solution of protargol or argyrol must contain from 25 to 50 per cent. of the remedy.

The solution of nitrate of silver, on the other hand, answers an entirely different purpose: After the stage of purulent secretion has subsided and the conjunctiva presents the well-known papillary appearance, a 1 per cent. solution of nitrate of silver is indicated—not as a germicide, but as a stimulating and irritating agent, intended to bring

the mucous membrane back to a normal state of smoothness; in this stage, applications of the stick of sulphate of copper will accomplish the same result.—Chas. H. May, Editorial *Archives of Pediatrics*, Vol. 22, No. 2, 1905.

#### **Mastoid Operation in Early Infancy.**

—Dr. Hopkins exhibited an infant to the Philadelphia Pediatric Society last October, with middle ear disease, in whom radical operation for mastoiditis was performed at nine weeks of age. The facial palsy occurred before operation.

Dr. L. J. Hammond said that cases of facial paralysis should be of great interest both from the standpoint of diagnosis and prognosis. Not only is it extremely important to differentiate in which of the three possible regions the nerve is involved, but as well the cause of the involvement should be considered before it would be possible to say what the outcome of any individual case would be. The nerve may be involved intracranially, intrasegmentally or peripherally.

His experience has been that in most cases the lesion has occurred in the bony segment, arising from disease of the middle ear. The group of symptoms characteristic of lesion within the Fallopian canal, external to the geniculate ganglion, are complete unilateral paralysis of all muscular movements, absence of hemiplegia, decidedly abnormal electrical reaction, loss of reflex associate movements, paralysis in the upper and lower halves of the face. The fauces, palate and uvula may also be paralyzed, through the interference with the great superficial petrosal nerve just before it joins the sphenopalatine ganglion. If, however, the ganglion is involved, we have, in addition to the before-mentioned paralysis, dryness of the mouth on the same side, with some loss of taste in that half of the tongue, and increased sensitiveness to musical sounds.

When the paralysis is of central origin, anywhere between the nucleus in the pons and the bottom of the internal auditory meatus, paralysis is not complete, as the branches supplying the eyelid are not affected: thus winking is possible. This is a point of great importance in the differential diagnosis. There is also associated with the intracranial lesion hemiplegia of the opposite side; electrical reactions may be normal; there will be persistence of the associate reflex movements; there is muscular atrophy throughout the area of distribution of the nerve; there may be internal squint from the involvement of the abducens nerve; some degree of deafness may also exist because of the involvement of the eighth nerve.

When the lesion is peripheral the paralysis may not be complete, as it will involve only those muscles that are controlled by the special fibres involved.

Should conservative treatment not bring about recovery within a reasonable time, surgical treatment, with the object of removing the pressure when the involvement is within the bony segment, should be regarded as judicious, and his experience in operations of this sort has been eminently satisfactory.

Dr J. P. Crozer Griffith said, with regard to facial paralysis in early life, that the disease in his experience was certainly extremely uncommon. During seventeen or eighteen years of dispensary practice he had observed the condition very seldom. It is, of course, probable that more cases would appear in dispensaries devoted to diseases of the ear, since affections of this class were by far the commonest cause. This did not, however, apply to the instances developing in the new-born, where injury by instruments was undoubtedly the most common cause.

Dr W. G. B. Hatland said that when the lesion is central it is, of course, on the side opposite to the facial palsy, whereas, when in the bony canal or

periploral part of the nerve it is on the same side. If the nerve is affected after its exit from the bony canal the paralysis is usually only partial, the forehead and eye escaping. Most cases of facial paralysis occur in older people, not in children.

#### **Carcinoma of the Bronchus and Liver Associated with Glycosuria in youth.—**

The patient a male aged seventeen years, was admitted to hospital with cough, shortness of breath and loss of weight. Family and personal history negative. He first noticed the cough about three months before admission and expectorated large amounts of bloody sputum. A month before he was admitted he began to complain of itching and developed an unnaturally great appetite and thirst. Then the amounts of his urine increased. A few days before admission his hands and legs began to swell. On admission he was pale, thin and cyanotic. Temperature 100.6 degrees F. Both legs were covered with gangrenous purpuric spots. There were several edematous swellings on the trunk. The liver was enlarged. There was marked bronchial breathing. He had diarrhea. The urine was loaded with sugar and gave a faint reaction for diacetic acid. He died suddenly the day after admission. The bronchus of the lower lobe of the left lung was the seat of a columnar celled carcinoma. There were smaller areas in the upper lobe. The liver showed many large nodules with softened summits. There were small deposits in the retro-peritoneal glands and the posterior cervical glands.—*Lancet*, April 1, 1905. Hull & Tribe

#### **BOOK REVIEWS**

**REFERENCE HANDBOOK OF THE DISEASES OF CHILDREN.** Reference handbook of the diseases of children, for students and physicians, by Prof. Dr. Ferdinand Peubwald, Chief of Clinic in the Vienna Polyclinic. Edited, with additions, by

Thompson S. Westcott, M. D., Associate in Diseases of Children in the University of Pennsylvania, with 176 illustrations. Philadelphia and London. W. B. Saunders & Company, 1906.

This translation of the well-known *Kompendium der Kinderkrankheiten* of Ferdinand Frühwald, by Westcott of Philadelphia, is a valuable addition to our already well-developed American pediatric literature. It is a very faithful translation of the original, with which we are all so familiar. Where any change has been thought necessary, either for greater clearness or to reflect the differences in practice in our country, it has been indicated in brackets, as editorial notes. The reader may therefore feel that he has before him unchanged, the benefit of the authors unusual experience as a practitioner in Vienna and a teacher in the Vienna Polyclinic.

The alphabetical arrangement of diseases will seem rather novel to American readers, but the numerous cross references render it extremely convenient for ready reference, without the necessity of consulting a special index. Indeed the author considers that this arrangement renders the compendium useful as a practical reference book, which it undoubtedly does, although the individual diseases are briefly presented, still they are sufficiently exhaustive for practical purposes.

Special stress has been laid upon the symptomatology of disease, as without a thorough knowledge of the symptoms it is impossible to make a diagnosis. Prophylactic, therapeutic and dietetic measures are fully discussed. The treatment shows the most recent achievements in therapeutics, but the author has shown good judgment in mentioning only such newer preparations as his hospital and private practice have taught him to have confidence in. By arrangement with the foreign publisher the illustrations are printed from the original plates used in the German edition, a few extra American plates have been added

as the editor's judgment dictated. Most of the illustrations are from cases at the Vienna Poliklinik. The author has freely consulted standard German works to supplement his own experience of many years.

The American reader can feel that he not only has the advantage of Frühwald's erudition in this book but that the opinions of such eminent pediatricists as Hensch, Gerhardt—Seifert, Biedert, Fischl, Unger, Lange, Brückner, Filatow, Ortner, Kretz, Mracek, Grätzer and Keller are also before him in the pages of this book.

The compendium is in no sense designed to take the place of the textbooks but it is rather a convenient clinical guide and a stimulant to the textbook study.

The book can in no way transplant our favorite American books but to the student it is valuable as reflecting the German opinions. To many they will seem curiously at variance with ours, notably so in the chapter on the treatment of appendicitis and that on artificial feeding.

W. A. E.

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Alcohol in *diabetes* is advocated by *American Medicine* on the ground that there is reason to believe that the first step in sugar metabolism by the cells is to convert it into alcohol. During the period then that sugar and starches are withheld it is believed to be well to deliver alcohol to the cells in minute doses and frequently, in order that the body may, by being built up, secure control of sugar metabolism. Small doses frequently repeated and well diluted appear to give excellent results.

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Gelsemium in combination with sodium bromide is recommended in *infantile convulsions*.

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*Styes* are said to be quickly cured by frequent bathing with listerine, diluted with three parts of water.



# SOUTHERN CALIFORNIA PRACTITIONER

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

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## EDITORIAL.

### A SYMPOSIUM ON ANAESTHESIA.

The current issue of the PRACTITIONER is able to present, what is to our mind, a valuable contribution to the subject of anaesthesia—not so much perhaps, that what is therein told by our colleagues of the Southwest, is so new or so different from what has in different times and places been stated by others, but because in brief compass, it presents the viewpoints of men who for various reasons, have become especially attached to some one or other anaesthetic.

There is no method of medical or surgical procedure which a medical man should approach with more trepidation and respect than that of giving an anaesthetic. Over confidence, unless the individual be unduly fortunate, usually brings a most prompt and awful reckoning. On the other hand, real danger lies in a lack of confidence. So great is

the danger from anaesthesia, that one may well say, that in its presence one is well within the borderland of the realm of death.

In days gone by, we purchased a number of books on this subject and were woefully disappointed in their contents. There was lots of printed matter, lots of it, but clear-cut exposition of the many details so necessary to observe in giving an anaesthetic, these were either lacking or hidden away in masses of hardly pertinent text. Because the symposium we publish pays particular attention to these details, we think it especially valuable.

Dr. Bullard's article on the "Indications and Complications of Ether and Chloroform," which he has allowed the poetical side of his nature to place before us in blank verse—he objects to its being called by that name, but no other term by which we could designate it

occurs to us—we deem worthy of special notice, and we have no hesitancy in asserting, that line for line, it contains more vital information on the subject, given in entertaining manner, than we have ever been able to find in printed form elsewhere.

It may, perhaps, be not entirely out of place in this connection, to remind our readers that the PRACTITIONER during the course of the year has printed many articles of value equally as great—for instance, the series of articles on "Feeding in Infancy and Childhood," which our Department Editor, Dr. Wm. A. Edwards, has recently been presenting—and that with such articles (leaving out of account the fact that the PRACTITIONER is, in a sense, both by historical association and by present scope of its contents, the mouthpiece of the profession in the Southwest), it is well worth the while for our subscribers to preserve for future reference their files of the SOUTHERN CALIFORNIA PRACTITIONER.

We are certain that those who do so will find these files of value and interest in future days.

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#### NEW FACULTY OFFICERS OF THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA.

On October 15th Dr. Walter Lindley as Dean, and Dr. Wm. D. Babcock as Secretary of the Faculty of the College of Medicine of the University of Southern California, closed their terms of office. Owing to his many other responsibilities, Dr. Lindley felt unwilling to longer serve as Dean and in his stead the faculty elected Dr. Wm. D. Babcock, whose former position as Secre-

tary was filled by the election of Dr. George H. Kress to that office.

The retiring Dean, Dr. Lindley, has been identified with the College of Medicine since its founding, twenty-two years ago, and the faculty was very loth to have him relinquish the position in which his executive work had proven of such great value.

In the election of Dr. Wm. D. Babcock as Dean, the faculty secures the services of a member who has been identified with the institution for almost twenty years, and who for almost a decade has been its efficient Secretary, acquiring in that capacity and time, an intimate knowledge of the needs of the institution, which no doubt, will stand him in good stead in his new work.

The College of Medicine of the University of Southern California, with its excellent lecture, laboratory and dispensary buildings and equipment, with access to the splendid Barlow Library, and with its experienced corps of teachers, was never in better position to do educational work of the highest standard, than now, and the auspicious circumstances under which the twenty-second annual session opened, are an indication that the fair name and fame of the institution will be as well guarded in the future as in the past.

The new officers assume their duties with the best wishes of faculty and friends.

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#### THE SOCIAL FEATURES OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION.

The threefold function of a county medical association—one, the scientific development of the members; two, the

development of the social and fraternal relations between members; and three, the safe-guarding of the material interests of the profession, have been considered in these columns on occasions more than one, and their relative importance discussed.

Inasmuch as the Los Angeles County Medical Association maintains weekly meetings, has prosperous sections in the specialties as well as branches in nearby towns, the scientific development of the members would seem to be and is, well cared for. As to the material interests of the members these will take care of themselves if the scientific and social features and aims of the organization be well developed.

At the present time, the social ends of the organization alone seem to be in need of additional attention. Not that there does not exist in Los Angeles an excellent feeling of fellowship among the members of the profession, but because the environment of this rapidly growing section makes difficult, the interchange of those professional courtesies which can be of such immense value in the development of county medical association work.

Affiliation with a county medical association is now absolutely necessary if a practitioner would step into state or national organizations, and as it is in the county unit that all ethical practitioners meet, it is here as nowhere else, then, that the cultivation of social and fraternal relations should take place.

Attempts have been made on a number of occasions to institute measures in the Los Angeles County Medical Association which would have as their es-

pecial purpose the fulfillment of the social ends of the organization.

More recently, the present President of the Association, Dr. F. C. E. Mattison has entertained the Society at his own expense and at the October Clinical Meeting he donated the equipment necessary to the proper service of an informal buffet lunch.

It is the hope to have this buffet lunch once a month, on the evening of the Clinical Meeting, the menu to consist of sandwiches and relishes, coffee, ale and cigars.

Now, that the necessary utensils have been purchased, the cost of such an informal lunch need not exceed the sum of ten dollars, this being the estimated cost for an attendance of fifty members.

It is believed that this sum could almost be raised by voluntary subscription at each such meeting but it has been suggested that a better method would be an allowance of ten dollars by the trustees of the County Medical Association, for every such monthly meeting.

It has been well contended, that no similar sum of money, no matter how expended, could net the Association better returns than would come from the increased loyalty and good feeling between members that would be built up through these informal lunches.

This we believe, was the sentiment of all who took part in the October Clinical Meeting and November will no doubt, register a similar expression of opinion.

We have written at length on this seemingly trivial topic because it has an intimate relation to the continued progress and prosperity of the Los Angeles



County Medical Association—which now is, and which we hope always will be—the banner county medical association of the Golden State.

NOTE.—Since writing the above, the November Clinical Meeting has been held at the Los Angeles County Hospital. The subject is only briefly referred to at this time in order to call attention to the fact that the Association at this meeting passed resolutions requesting the Trustees to set aside the sum of ten dollars monthly for the purchase of refreshments, so that the clinical meetings of the future will in all probability be marked by this feature.

We are so sure of its value in our own mind that we have no hesitancy in predicting that once given a thorough test, and the habit formed, the custom will never be dispensed with.

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### THE THIRD ANNUAL REPORT OF THE BARLOW SANATORIUM FOR POOR CONSUMPTIVES.

In 1900, a Los Angeles physician who had some years before come to Los Angeles from New York, after a sojourn in the Adirondacks, where he had striven to overcome the disease in which he subsequently became greatly interested—purchased over in the Chavez Ravine Valley, between Elysian Park and Sunset Boulevard, a tract of twenty-five acres, which grounds he hoped to see utilized as the site for sanatorium buildings, where the worthy tuberculous poor of Los Angeles might be given a fair chance for the recovery of their health and the prolongation of their lives.

In September, 1903, due almost solely to his efforts and work, the buildings had been erected and the funds provided, so that the institution was able to open its doors for its first patient. The third annual report of that institu-

tion has just been sent to its friends and contains so much interesting and valuable information, that an editorial consideration thereof seemed desirable.

The total number of patients admitted in the last three years has been almost 300, the list of applications for admittance, however, being three to four times that number.

The patients admitted during the last year, classified by stages, according to Turban, showed a marked preponderance of third and second stages, these being 48 third, 9 second, and only 5 first stage patients. It would be a great pleasure to the friends of the institution if conditions were such that it could confine itself to sanatorium or heilstatten or healing place work; for to stop a tuberculous process in the incipient stage of the disease, means saving to the state, a citizen whose usefulness and value would be but little impaired.

The circumstances have been such, however, that this more interesting and in one sense, more utilitarian work with incipient tuberculosis, has been forced to give way to the more urgent call of the humanitarian instinct. The sad lot and hopeless misery of the many third stage patients who have been admitted, was so great, that the institution opened its doors to many, whom it knew it could neither improve nor cure. In following this course, it was partly compelled to do so, because the city and county of Los Angeles may be said to be almost indifferent to the misery associated with this disease, of which there is so much in our midst.

The results of treatment of these advanced cases of tuberculosis, has been by no means discouraging. Thus of the

be patients for the year just closed, who left the institution, eleven died, ten were unimproved, twenty-eight were improved, six showed arrest of the disease, and three were apparently cured.

During the last year, in addition to improvements, costing several thousand dollars, made by Mrs. Solano and Mrs. Barlow in the main buildings, the grounds at a cost of more than four thousand dollars, were greatly improved and beautified by the family of the late president of the board of directors, the late J. S. Slanson, Esq. The recent very successful garden fete which netted more than thirteen thousand dollars, an evidence at once of the generosity of the people of Los Angeles as well as of the executive ability of its manager, Dr. Barlow, whose untiring efforts were largely responsible for such a handsome result, belongs properly to the receipts of the fourth year of the institution.

It may seem at times, that there is almost too much discussion of tubercu-

lous conditions in Los Angeles, but every practicing physician must know what a vast amount of suffering and almost hopeless misery many of the unfortunate victims of the great white plague, who have come to this community, are forced to undergo.

Because of this great amount of physical sickness and pain, as well as the accompanying mental distress, and because every effort to mitigate the disease, is at the same time a blow in favor of more hygienic and sanitary living, we should be grateful that even though the county and city of Los Angeles be negligent as to their responsibilities in the problem, philanthropic men and women have been generous enough to give at least a portion of our unfortunate consumptives a fighting chance for health and life.

To those who have not received reports, but who are interested in the work of the Barlow Sanatorium, copies of the third annual report will be gladly sent.

## EDITORIAL NOTES.

Dr. Arthur W. Walker has resumed practice in Riverside.

Dr. F. J. Bold, formerly of Imperial, has located in Whittier.

Dr. R. D. Wilcox, an oculist, has located in Phoenix, Arizona.

Dr. Angus D. Cameron of Riverside has returned from Europe.

Dr. Corwin is again located in San Dimas, Los Angeles County.

Dr. C. D. Lockwood of Pasadena has returned from a European trip.

Dr. Arthur A. Libbey of Pasadena has returned from an eastern trip.

Dr. J. M. Ford of Phoenix, Ariz., has been fishing at Catalina Island.

Dr. Amos Martinez of Phoenix, Arizona, has returned from New York City.

Dr. D. A. Clark, formerly of San Pedro, has located in Los Angeles.

Dr. and Mrs. Hoell Tyler of Redlands, have returned from New York City.

Dr. Fred Williams of Bisbee, Arizona, is suffering from a dislocated ankle.

Dr. Oscar J. Kendall of San Diego is doing post-graduate work in Chicago.

Dr. P. G. Cornish of Albuquerque, N.

M., has returned home from New York City.

Dr. A. R. Hickman, of Douglas, Ariz., is just recovering from an attack of appendicitis.

Dr. Edward J. Cook of Los Angeles is doing post-graduate work in New York City.

Dr. G. G. Moseley of Redlands has returned from doing hospital work in eastern cities.

Dr. H. Bert Ellis of Los Angeles, who has been very ill, is now again attending to his practice.

Dr. C. L. Edmundson of Lowell, Arizona, was recently called professionally to Los Angeles.

Dr. W. W. Phillips of Rosewell, New Mexico, has been doing Hospital work in New York City.

Dr. Harvey J. Hall and Dr. Lura J. Brown of Los Angeles are to be married on December 11th.

Dr. Rea Smith is east and will devote most of his time while away to the hospitals of New York and Chicago.

Dr. Guy Cochran, surgeon of the Salt Lake Road, is spending a few weeks in the hospitals of New York and Philadelphia.

Dr. W. V. Nichols of Oceanside, Cal., has been spending ten days in San Francisco, as delegate to the Masonic Grand Lodge.

Dr. Arthur M. Smith, Police Surgeon of Los Angeles, was married on October 18th to Miss Helen Leona Milligan of Chicago.

Separate cottages for the treatment of tuberculosis patients are being erected at the Southern California State Hospital for the Insane.

Dr. John Durben Thomas of Philadelphia was married on October 2nd to Mrs. Elsie L. Passmore Hamrick of Anaheim, Orange Co., Cal.

Dr. Dumont Dwire, formerly of Oxford, has resigned his position as County

Health Officer of Ventura County and located in the City of Los Angeles.

Dr. H. Z. Gill of Long Beach recently celebrated his seventy-fifth anniversary. It was the occasion of many delightful congratulations and suitable presents.

Dr. John R. Haynes has returned from a very interesting European trip, during which he spent most of his time in Russia, Finland, Norway and Sweden.

Dr. E. V. Lonigo, formerly Sanitary Inspector of the City of San Francisco, has established his offices in that city at 1742 Union St., between Octavia and Gough.

Dr. C. H. Hughes of St. Louis, a distinguished alienist, has been spending some time in Southern California. We very much regretted that we did not see more of him.

In France there were eleven hundred less medical students in 1905 than there were in 1895, not counting foreign students whose numbers had diminished 46.8 per cent; that is, from 1137 in 1895 to 604 in 1906. In the United States there was a decrease in 1906 of about 25 per cent.

At a recent meeting of the Ventura County Medical Society, held at the residence of Dr. J. C. Bynum in Ventura, after the scientific paper and discussion all partook of a delightful collation served by Mrs. Bynum and her daughter Miss Ruth. Dr. Bynum read a paper on the benefits of electricity as a therapeutic agent.

At the annual meeting of the stockholders of the Santa Ana Hospital Association the following were elected as a board of directors: Drs. J. L. Dryer, H. S. Gordon, F. M. Bruner, J. R. Medlock, Willella Howe-Waffle, C. D. Ball, John Wehrly, and Messrs. A. J. Visel, Wm. F. Lutz, D. H. Thomas and H. S. Forgy. The board organized by electing Dr. Dryer, president; Dr. Bruner,



vice president; Dr. Ball, secretary and Dr. Gordon, treasurer.

The Fifth Annual Report of the Children's Hospital of Los Angeles, being a statement of the work for the year ending April, 1906, has just been received. It is a very creditable publication and shows that this worthy institution has cared for 229 children during the year. The president, Mrs. Florence D. Johnston speaks very highly of the faithful and untiring services of Dr. John A. Colliver and Dr. Randall Hutchinson. Mrs. Dan Murphy, 2858 Orchard Avenue, is chairman of the Subscription Committee.

The "Auditorium" is a building just completed in Los Angeles at the corner of Fifth and Olive streets. It is an absolutely fire proof building, costing about a million dollars. The moving spirit in its construction has been Mrs. Robert J. Burdette, whose wonderful executive and constructive ability has been here most successfully utilized. Two floors of this building will be devoted to physician's offices, and among those who have already secured offices there are: Drs. J. T. M. Allan, Sumner J. Quint, Norman Bridge, H. F. True, Geo. L. Cole, Fred C. Shurtleff, Wm. Duffield, O. O. Witherbee, Geo. J. Lund, C. B. Dickson, Mary J. Green, C. G. Stivers, Frank Zelinsky, Francis B. Kellogg, G. A. Scroggs, Mary L. Noble, J. H. Martindale, F. S. Barnard, T. C. Low, Nannie C. Clark, B. Roswell Hubbard.

The sixteenth annual meeting of the Southern California Homeopathic Medical Society was held in Los Angeles on October 10-11. The officials for the coming year are: president, Dr. J. S. Hunt, of Santa Monica; vice-president, Dr. F. B. Kellogg, Los Angeles; second vice-president, Dr. Helen Woodruff, Los Angeles; secretary-treasurer, Dr. F. S. Barnard, Los Angeles. The members of the board of censors and the board of directors for the last year were re-elected to office. The legislative and re-

ception committees will be appointed to-day.

Dr. W. J. Hawkes, of this city, acted as chairman of the meeting, and interesting papers were read by Dr. G. Max Webster; Dr. S. H. Boynton, Dr. Frank D. Bishop, Dr. W. J. Hawkes, Dr. M. W. Hill, Dr. W. E. Nichols, Dr. H. A. Atwood, Dr. W. H. Sules and others.

For those who may desire to practically assist in the work of the Barlow Sanatorium for Poor Consumptives we republish from recently issued third annual report the following:

"You can endow a bed for all time, and nominate the patient therefor, by the payment of five thousand dollars to the endowment fund."

"You can become a life member and so contribute to the endowment of a perpetual bed by payment of one hundred dollars.

"You can become a patron by giving fifty dollars or more annually.

"You can become a subscribing member by giving ten to forty dollars annually.

"You can become an annual member by giving five dollars annually."

Robert A. McLean of San Francisco has his offices at 801 Van Ness Avenue and his residence 1825 Sutter street.

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*For the control of nasal hemorrhage* tampons can be readily prepared as follows: A layer of cotton is wound around a penholder or similar object until the desired thickness is obtained, and then withdrawn. The cotton cylinder is then moistened, squeezed dry, and inserted into the nasal cavity. If the projecting end of the tampon is now moistened it will swell up and thus produce sufficient compression.

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*Cannabis sativa* is valuable in the treatment of cough of phthisis increasing the sense of well-being of the patient.

# TWENTY-ONE YEARS AGO IN LOS ANGELES.

EXCERPTS FROM THE SOUTHERN CALIFORNIA PRACTITIONER OF VOL. I., NO. 11, NOVEMBER, 1886

"We are prone to look upon tuberculosis as something invariably malignant, but this idea modern pathology repels. Niemeyer said "That the finale of tuberculosis is as a rule death," but Carswell, more benignant in his prognostications, said: "Never has pathological anatomy adduced clearer proofs regarding the cure of a disease than by phthisis." Baumgarten observes that in every three or four cadavers he has found unmistakable resolutions of tuberculous processes and likewise in many other organs. The statements of Baumgarten have been corroborated. In nearly every cadaver tuberculosis products are found, although during life their existence is in no wise manifested. A celebrated physician once said: "That in the long run nearly everybody has a little tuberculosis." (*Excerpt from an original article entitled "SCROFULA," by Albert Abrams, M.D., San Francisco, Cal.*

\* \* \*

"In mental and physical depression due to prolonged excitement this drug is of value. One of my students took from six to eight hundred drops daily of the tincture, and thereby successfully tided himself over a period of great strain. In fact, he studied harder and kept later hours than at any other examination period, and with less detriment to his health. He is myopic and astigmatic, and this was the first time he came out of his studies without suffering from eye-strain. The doctor writes me that he has used the drug since in practice under similar circumstances. For instance, it helped along well a young society girl, who was usually busy with engagements until the rush was over. The uses of the drug are as dangerous, however, as the use of any stimulant, and should be given only on extraordin-

ary occasions for the purpose indicated. Its use as above serves to show its power as a nerve-stimulant." (*Excerpt from a selected article entitled "THE THERAPEUTICS OF NUX VOMICA," by J. H. Musser, M.D., Philadelphia, Pa.*)

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"I can only say, with increasing experience, my own practice has grown more and more conservative, and my own belief is that true wisdom requires us to abstain from even trivial operations so long as Nature is able to do her work without our assistance.

"Second: If assistance is necessary, cannot the required aid be rendered by the hand with as much ease to operate and less risk to the patient than by forceps? \* \* \*

"Third: As extension is the *sine qua non*, how is it most easily and safely attained? It is only necessary, in most instances, to pass two or three fingers up the rectum until the supra-orbital ridge is reached, then make traction of the foetal head in the direction of the axis of the outlet. \* \* \*

"The great majority of perineal lacerations is caused by too precipitate delivery; this alone should make us guarded in the use of forceps.

"If it does become necessary to use the forceps, what precautions are essential? The instrument is to be used as a tractor, and, as axis-traction is the law, it follows that traction must be upward and forward-upward first, and forward if need be. If the forceps have been applied as suggested, and axis-traction continued until the face cleaves the perineum, the handles will be lying horizontally upon the woman's abdomen." (*Excerpt from a selected article on OBSTETRICS by F. M. Johnson, M.D., Kansas City, Mo.*)

"A short time ago one of the three heads of the PRACTITIONER happening to have need of the services of one of those tonsorial artists, known to our plain-speaking ancestors as barbers, passed within the portals which are guarded by the staff and red bandage of medieval chirurgy. In the show window stood a goodly array of numerous brands of infallible hair restorers and invigorators; and the editorial head (beginning to tinge with the silver which comes with work and years) thought within itself, while I may be careless as to gray, I need never be under the necessity of wearing a wig to protect my bare pate from the inclemencies of that winter of age whose autumn frosts I begin to see. And thereat much did the editorial head felicitate itself upon the great progress of science in these latter days, and the pitiable condition of our hairless elders.

"But upon entering, a startling face dawned upon the editorial vision. Behind the well known row of red-velveted chairs stood a row of baldheaded barbers, neither were they men of advancing years, but rather in that dreamy age when life is yet bright before the youthful mind. \* \* \*

"How is it that with all these infallible hair restorers at your command, so many of you barbers are bald?

"The reply, given with the air of one betraying one of the secrets of the guild, was "Too much shampooing."

"You see," said this man of the razor, "the rubbing works the soap into the roots of the hair and dries them up."

"Is it after all the best thing for the human scalp to thus periodically scrub it with strong alkaline soaps as though man does it, and at forty his bald pate, despite his numerous hair restorers, shines like the smooth surface of a pumpkin. The savage does not do it, and at eighty he has a head of hair like the shaggy mane of a bison. It is all very well to talk of being clean, but nature evidently intended the human head to be covered with hair, and cleanliness

carried to the point of scalping may be somewhat of an excess. The text of the editorial of last month may not be amiss as an appendix to this. "Be clean! be clean! but be not too clean." (*Excerpt from an editorial entitled "THE SCALPER OF CIVILIZATION."*)

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"The New York and Brooklyn medical men of note are just arriving home from their European tours and relieving their young summer substitutes. Bellevue, University, Polyclinic and the Post-Graduate are all at work with their usual quota of students. I saw Dr. Paul F. Munde operate for lacerated cervix at Mt. Sinai Hospital a few days ago. He had four female nurses, and one male nurse and three house physicians to assist him. \* \* \*

"One of the best lecturers I have been permitted to listen to in New York is Dr. Wm. A. Hammond. Amongst other cases presented at his clinic was one of hysteria. He said "When I was a young doctor we would souse a hysterical woman with several pails full of cold water. Thank God that brutal treatment is of the past. The sovereign remedy is some form of the bromides. I will prescribe for this young woman the following solution:—

Bromide of sodium, one ounce,

Fairchild's pepsin, one and one-half drachms,

Charcoal, three drachms,

Water, four ounces.

Mix. Take one teaspoonful three times daily after meals.

"This young woman has particularly violent paroxysms at night, and besides the prescription I have just given I shall also have her take sixty grains of bromide of sodium in a half glass of water at bedtime. As I said before, bromide of sodium is the sovereign remedy." Professor Hammond lectures at the Post Graduate School. (*Excerpt from an EDITORIAL LETTER from New York, by W. L.*)



"The opening exercises were held in the College Hall, October 15. Addresses were delivered by the Rev. M. M. Bovard, A.M., President of the University, by J. P. Widney, A.M., M.D., Dean of the College, and Dr. Kurtz, Professor of Clinical Surgery.

"The students had secured the services of a fine orchestra for the occasion, as a surprise to the Faculty, and had tastefully decorated the hall, whilst a pleasant address of welcome to the new students and to the Professors had been prepared.

"The College opens out its second year with very flattering prospects. The class has been doubled, new supplies of appliances, including a number of microscopes, have been provided; and plans are rapidly maturing for the erection of the new college buildings. The college is destined to quickly become one of the strongest centers of medical education upon the Pacific coast." (*Excerpt from an editorial note entitled "THE OPENING OF THE SECOND YEAR OF THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA."*)

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"A few days ago the surgeon in charge of Dr. G. W. Lasher removed the two large drainage tubes from the knee-joint and dressed the limb in silicate plaster.

"The Doctor was yesterday removed to his father's at Germantown on the Hudson. He is very anxious to renew his work in the medical college at Los Angeles, and from his present rate of recovery I think he can do so before many months."—(EDITORIAL NOTE.)

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"During the past few years many letters have been received at this office from licentiates complaining that the medical law was not enforced, and some indeed feeling that it proved a hardship rather than a benefit to them, inasmuch as the "illegal practitioner" who was

free to avail himself of any means for the advancement of his own interest, flourished like "a green bay tree;" while he who desired to be a law-abiding citizen and to conform to the code of ethics, was unable to overcome the evil without assistance; hence appeals were made to this Board for help.

"To that end circular letters were sent out last year to prominent medical men in different localities urging them to establish local medical societies, that an organized effort might be made all over the State to suppress the illegal practice. In response to this effort a number of such societies have been formed. In order to aid them in the work, it was deemed best to issue a new addition of the *Medical Register*, as so many additions to the list of licentiates and changes in locations have been made during the last two years, that the edition of 1885 is no longer reliable as a book of reference in such proceedings. \* \* "

"We expect to publish 2,500 copies of the Register, and gratuitous distribution will be made among the licentiates of this Board residing in this State. We hope to have it ready by the 1st of January, 1887. R. H. Plummer, Sec'y Board of Examiners." (*Excerpt from Correspondence Column in regard to the "STATE MEDICAL LAW."*)

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Dr. Walter Lindley of the SOUTHERN CALIFORNIA PRACTITIONER, read a paper October 19, before the Kings County Medical Society, Brooklyn, N. Y., on the "Climate of Southern California." (*Editorial Note.*)

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The success of women in the medical profession in the East has not been won without many a bitter struggle. They were openly jeered at, and it is stated that on one occasion they were driven from the room in the old Pennsylvania Hospital while the clinic was in progress by the male students. (*Editorial Note.*)

## CORRESPONDENCE.

DR. KATE WILDE VISITS DR. MAUD MACKEY  
IN CHINA.\*

To the Editor:

Shanghai had just settled down, after the troubles of December 18, 1905, when we arrived, February 13, from Manila, via Hongkong.

Visited the Chinese quarter, but the people looked sullen and disturbed. The weather was cold and crisp, then drierling, somewhat the same as one would experience in the winter in Paris.

The Chinese wear, universally, the padded coat, even to the beggars, such as it is, and if one wants to see dirt and rags, one can, certainly, see them to the fullest advantage in China.

The morning of the 15th chose the voyage up the Yangtse Kiang, for the interior of China, Tientsin, at this season, being iced in. The steamers, both Japanese and English, are good, but the boat's progress was retarded by falling snow and bad weather in general. Various ports are made up the river, and the taking on and off of the Chinese passengers was of interest. Three or four days are consumed before reaching Hankow, the so-called Chicago of China. At Hankow, there is, as usual, the "Bund," along the water front, and the foreign concessions bordering upon it.

Weather intensely cold.

A French railroad runs between Hankow and Peking, and the crossing of the long bridge, over the Yellow River, is interesting. Many of the Chinese employes, on the road, are taught to speak the French language, in the Catholic institutions, in Peking.

The trip to Paoing fu from Hankow takes three days, at the above season, the train coming to a full stop, at night. The Chinese boy will keep the heater

going in the car, during the day, but it gets cold before morning. Later in the season there is a good through service. It is a privilege to remain in the car to sleep, as otherwise one would have to spend the night in a miserable Chinese inn.

The night calls or sounds, in China, are well known, but give one a sensation akin to uneasiness in troublous times. Whenever the car was side-tracked for the night, the Chinese would come across the fields from all directions, to stand and gaze at the foreigners, through the car windows. Calm, concentrated, absolutely absorbed, and seemingly lost to all else but the interest taken at the moment. There are armed Chinese soldiers at each station.

Food stuffs are sold along the route. The pears are rather nice, but taste somewhat like a sweet watery turnip. Peanuts sold all along the route.

Smallpox is quite universal, judging from the amount of pitting that one sees among the crowds of Chinese who throng the stations.

Dr. Maud Mackey of the American Presbyterian Mission, is stationed at Paoing-fu, which is reached a few hours before the arrival of the Hankow car in Peking.

The Compound is surrounded by a high gray brick wall, and is situated a short distance from the walled city of Paoing-fu. The site of the older buildings of the Presbyterian Mission, which were destroyed in 1900, during the Boxer uprising, has been kept as a cemetery.

There are in the present Compound, detached buildings for the inmates of the Mission, a long low line of buildings used as a girl's school, and two two-story hospitals. All are of gray brick, as wood is expensive in China.

Dr. Mackey has charge of the hospital for the women, and Dr. Lewis is

\*Dr. Wilde, in her latest trip around the world, took occasion to pay a visit to Dr. Maud Mackey in China.

in charge of the one for the men. High walls separate the two hospitals, according to Chinese custom. Dr. Mackey learned that many patients preferred remaining outside in small rooms, open-out onto the ground enclosure, rather than to remain in the hospital proper, during convalescence. One can see, often, therefore, a complete and separate household formed, the patient being waited upon by some Chinese friend or relative of his own choosing. Dr. Mackey will supply millet seed to patients waiting for attention, who have come long distances, and who are unable to keep themselves.

In the field of operative work in China, there are many difficulties one never encountered here. To cite an instance

Some years ago Dr. Mackey sought to remove the leg of a Chinese girl, a case of tuberculous bone disease. The mother of the child insisted that should the operation be performed, the girl could never marry, that she had no money to keep her, and that both must kill themselves with opium as the solution of the difficulty. To prevent this, Dr. Mackey secured a certain paper from the mother and the girl became her own property, absolutely. On her wooden leg the child is now a good little hospital helper.

Dr. Mackey attends her dispensary in Paoting-fu twice a week, going and returning by rickshaw. Other days the patients apply to the hospital proper, in the Compound.

Dr. Mackey speaks Chinese fluently, is occupied fully with her work, and is contented to remain in China. She will be home on furlough, next year, having been in China since 1899.

Tientsin is interesting, as the port for Peking. The inevitable wall surrounding a Chinese city, was leveled, as a punishment, after the Boxer troubles of 1900. An electric tram service has

now utilized the space formerly occupied by the wall.

The Bund was quiet until the breaking up of the ice in March, when the steamers waiting outside came in over the bar, the first boat arriving at the Bund being received with acclamation. Then a scene of warehouses thrown open and loading and unloading of the vessels by a horde of colliers. Life seen in its busiest mood.

Yuan Shi-Kai, the Viceroy of the Province of Chili, is proforeign and one of China's greatest officials. People look to him as a man holding great responsibility. Visited a Chinese school for girls, established by him in Tientsin. English is taught for one-half the day. To be able to speak English is the great desire of the Chinese heart today.

KATE WILDE.

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CHRISTIAN SCIENCE PUBLICATION COMMITTEE TAKES EXCEPTIONS TO DR. SAWYER'S STATEMENTS CONCERNING CHRISTIAN SCIENCE.

Los Angeles, October 20, 1906.

*To the Editor:*

In your October issue appears an article by Dr. W. B. Sawyer of Riverside, wherein he alleges that Christian Science is one of the "shadows" of *Materia Medica*, and since from my view point, his remarks are incorrect, misleading, and unjust they require correction and I ask that you kindly give me space for reply.

To begin with, the Doctor confuses Christian Science with hypnotism and mesmeric belief in the remedy and skill of the physician and imagines that they are identical, when as a matter of fact, the 'modus operandi' of Christian Science is exactly the opposite of that of hypnotism or mesmerism.

If the Doctor will take the time to read the Christian Science text book, *Science and Health*, by Mrs. Eddy, he will be convinced that Christian Science



has nothing in common with hypnotism or auto-suggestion.

When the Doctor finds fault with Christian Scientists for denying the existence of matter, he at once informs us that he has not kept pace with the more recent conclusion of the world's most eminent material scientists. In taking issue with Christian Science on this point he also takes issue with such thinkers as Professor Oswald of Leipsic University and Professors Crookes, Lodge, and Curie, the latter being the famous discoverer of radium.

The Doctor also complains that the finite mind cannot comprehend Christian Science and in this he agrees with the Scriptural statement in 1 Cor. 2-14 "But the natural man receiveth not the things of the Spirit of God for they are foolishness unto him; neither can he know them, because they are spiritually discerned."

Thus it will be seen that only through spiritual growth and purification is the Christian Science practitioner qualified to heal the sick and reform the sinner in accordance with Jesus' promise "He that believeth on me the works that I do, shall he do also."

Of course it is possible that the Doctor has come in contact with some who claim to be Christian Scientists but who are false claimants to the name. If such are not earnest and consistent followers of Jesus Christ, both in the spirit and letter, they are not Christian Scientists.

The Doctor's statements that "most of these people are honest and daft" and some dishonest and liars betrays a spirit of intolerance, ignorance and egotism that one hardly expects from one who undoubtedly considers himself an educated gentleman.

Because Christian Science differs from Materia Medica in its treatment of disease the Scientists do not consider the doctors are daft nor given to dishonesty and lying. On the contrary the Scientists entertain a high regard for the

noble army of unselfish men and women who are laboring so earnestly and sincerely to benefit mankind.

In conclusion I desire to respectfully suggest to Dr. Sawyer that it would be well for him to become somewhat acquainted with the subject of Christian Science before attempting to define it and furthermore it might be beneficial to him to contemplate that possibly *Materia Medica* has not absorbed everything there is to be known concerning the healing art.

This attitude of mind might lead him to discover something of the efficacy of Christian Science.

WILLIAM E. BROWN,  
*Asst. Christian Science Publication Committee.*

745 Whittier street.

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**DR. C. G. STIVERS WRITES CONCERNING THE  
OUT-OF-DOOR SUNLIGHT CURE  
FOR TUBERCULOSIS.**

CHICAGO, ILL., Oct. 28, '06.

*To the Editor:*

On my way to Chicago, I stopped at Fort Dodge, Iowa, to look over Dr. Kime's out-of-door sanitarium for consumptives. The following is a description of the buildings and of what I noted on my visit and you may use it for the *PRACTITIONER* if you like.

A visit to the Kime Out-of-door Sanitarium at Fort Dodge, Iowa, and a study of the results of treatment there, will convince the most skeptical that the essential feature of the plan is the constant out-of-door exposure combined with a generous diet. The Sanitarium is situated about two miles from the center of the city of Fort Dodge, Iowa, which town is on the Des Moines River and is reached by several trunk lines of railroads. It is a place of great natural beauty, and enjoys a commanding site on high ground overlooking the beautiful Des Moines River, which here runs between high bluffs, all heavily wooded with oaks and maples. The ele-

vation is greater than that of the surrounding country so that the drainage is good. Rain does not stand long on the surface, so that patients can walk around under the trees soon after a shower.

I drove out to the Sanitarium and found a two-story stone building in the forest; only part of the original building plan has been completed, as it has been found unnecessary to have such a large building as was originally planned, to accommodate patients. Further, the intention is not to house the patients but to keep them out of doors. The main building contains accommodations for 15, and this is where most patients sleep, always with open windows. The rooms are large, about 12x15, with a very high ceiling, and you can see by the size of the windows in the accompanying photograph that sunshine and good fresh air can be admitted freely to each room. A patient is admitted, we will say, in the stage of hectic fever, with cough, expectoration, temperature fluctuating between 98 degrees and 103 degrees every day; with no appetite, having night sweats and chills. He is at once put to bed and kept there until his temperature, pulse and respiration are normal, or nearly so. His treatment during this time consists of the administration of liquid food, daily warm bath (sponge) and frequent tepid sponging to reduce the temperature; medication is not much depended on. A little atropia for sweats, strychnine for depression, and a ferruginous and bitter tonic is generally all that is given. The sputum is collected in paper cones and burnt often. The patient's window is open, top and bottom, and there is a ventilating grate in the footboard or moulding near the floor, discharging into the open air through an opening under the eaves. When the patient's temperature is normal and he can be moved out of doors he is taken to the platform and there is left several hours each day—

the time of exposure gradually lengthening as the patient's strength improves. The sun's rays are reflected from a concave mirror built up of planes or small pieces of silvered glass, and focusing at about 4 feet from the mirror. The exposure to this mirrored reflection is about 30 minutes and patients declare they are burning when it is in operation on them. Each patient in the Sanitarium gets his daily sun bath by reflection. What good (other than psychological) it does, I cannot imagine. The subsequent history of such a patient as referred to above is generally one of gradually increasing strength and a full restoration to health, which is only limited by the extent and nature of such organic changes as are the personal characteristic of the individual.

The diet of out-of-door patients is a generous one. The menu for Sunday, October 21st, here follows:

*Breakfast, 7:30 a.m.*

Oatmeal.	Baked apples.	
Milk.	Fried eggs.	Gems.
		Coffee.
<i>Lunch, 10.30.</i>		
Milk.	Crackers.	Fruit.
<i>Dinner, 12 m. noon.</i>		
	Pearl Barley Soup.	
	Wafers.	

Fried Chicken.	Baked Sweet Potatoes.
Peas.	Celery.
	Pumpkin Pie.
	Milk.

<i>Lunch, 3:30 p.m.</i>	
Milk.	Crackers.
<i>Supper, 6 p.m.</i>	
	Cold Boiled Ham.
	Potato Patties.
	Graham Wafers.
	Cranberry Sauce.

Milk.	Cocoa.
-------	--------

On week days, meal hours one-half hour earlier.

The charge for each patient is \$20 per week. This does not include washing.

The results of treatment are good. One patient, a young woman, came in with a tubercular ulcer of the leg extending from the ankle to the knee. It

was thoroughly cleaned, curetted and dressed with Bismuth Sub-nitrate and a dry dressing. The mirror reflection was applied every morning for 30 minutes, and the leg dressed several times daily at first, less often as it improved. The case was sent out cured in six weeks.

Another case of pulmonary tuberculosis had two hemorrhages before admission, and was a walking skeleton. He gained 25 pounds in eight weeks. It was an incipient case.

The buxom red-cheeked attendant who showed me around said she had been a patient for three months with incipient pulmonary tuberculosis. She gained in all up to the present time, about thirteen weeks, twenty pounds, and now weighs 154 pounds, and is the picture of radiant health. The State of Iowa is looking around for a suitable State Sanitarium for Consumptives

and its commission has already recommended that it be located at Fort Dodge, Iowa. This will be the location if the Great Western Railroad will build a spur to the chosen site.

The day I visited the Sanitarium it was cloudy and drizzling rain fell all day. Not one minute of sunshine. And from now on to April it will be hardly different, except at rare occasions. What an advantage in this respect Southern California possesses only those know who have lived in both climates.

I have seen Murphy, Ochsner, Senn, Andrews, Barnes and William B. Morgan, a cluster of surgeons, operate in the free clinics in Chicago. In the five days I have been here I have witnessed over sixty major operations and have notes of all of them. \* \* \*

C. G. STIVERS, M.D.

## BOOK REVIEWS.

CHEMISTRY: GENERAL, MEDICAL, AND PHARMACEUTICAL, INCLUDING THE CHEMISTRY OF THE U. S. PHARMACOPOEIA. A MANUAL ON THE SCIENCE OF CHEMISTRY, AND ITS APPLICATIONS IN MEDICINE AND PHARMACY. By John Atwood, F. R. S., M. A. and Ph. D. and Leonard F. I. C., F. C. S., Professor of practical chemistry to the Pharmaceutical Society of Great Britain, 1862-1866; formerly demonstrator of chemistry at St. Bartholomew's Hospital, London; honorary member of twenty-three societies, associations, and colleges of pharmacy in Europe and America; one of the three editors of the British Pharmacopoeia, 1885; editor of the Addendum to the British Pharmacopoeia, editor of the British Pharmacopoeia, 1898, and of its Indian and Colonial Addendum, 1900. Edited by Leonard Dobbin, Ph. D. (Würzburg), F. I. C., F. C. S., Lecturer on chemistry in the University of Edinburgh, lately examiner in chemistry on the Board of Examiners for Scotland, of the Pharmaceutical Society of Great Britain. Nineteenth edition. Lea Brothers & Co., Philadelphia and New York, 1906.

The nineteenth edition of this manual has been revised from the eighteenth English edition and is adapted to conform to the new United States Phar-

macopoeia, an evidence at once of its popularity and its worth. The chief aim of the book, the author states, is to teach the science of chemistry to medical and pharmaceutical students, and this he accomplishes in most successful fashion.

Its comprehensive index of nearly ten thousand references to the text, add greatly to the value and usefulness of the volume.

The author states that "Chemical facts are not yet united by any single, consistent theory," and he therefore "has preferred to lead up, rather than follow scientific classification, has allowed analogies and affinities to suggest rather than be suggested by, classification." His ideal of a manual of chemistry for medical and pharmaceutical students is, then, one in which not only the science of chemistry is taught, but in which the chemistry of every substance having interest for the followers of medicine and





## This Index Finger

serves to point out and accentuate the fact—already known to thousands of physicians—that two tablespoonfuls of Colden's Liquid Beef Tonic, administered ten minutes before each meal, will produce far more effective results in the treatment of atonic dyspepsia than can be obtained by the exhibition of unlimited amounts of pepsin.

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pharmacy is noticed at more or less length in proportion to its importance, and at least its position in relation to the leading principles of chemistry is set forth with all attainable exactness.

The eighteen editions that have appeared since the first came out in 1867, (the last bears the author's comments of September, 1906) are the best evidence as to the worth of Attfield's Manual.

### AN INTRODUCTION TO PHYSIOLOGY.

By William Townsend Porter, M. D., Associate Professor in the Harvard Medical School. Cloth; 588 pages. Philadelphia and London. J. B. Lippincott Company, 1906.

In this book Porter presents not only an excellent laboratory guide in physiology but calls attention to the concentration system which he and Dr. Councilman were instrumental in inducing the

Harvard medical faculty to adopt. Under that system the first half year is devoted almost solely to anatomy and histology, the second half year to physiology and biological chemistry, the third half year to pathology and bacteriology, and the fourth, fifth and sixth half years to practical medicine and surgery. Upon Professor Bowditch's recommendation the seventh and eighth half years were made largely elective.

This system allows the student to pass in logical sequence from one thoroughly-mastered subject to the other, and permits him as a university man, at the end of his course, to have a voice in choosing the studies he is most interested in.

The book by Porter is an excellent guide book for laboratory work in

physiology and both in arrangement and subject matter in the text is well fitted to the needs of students. It has met with much favorable comment by laboratory teachers, and the demand for it has been sufficient to necessitate the publication of this second edition.

**RHYTHMOTHERAPY**, a discussion of the Physiologic basis and Therapeutic Potency of Mechano-Vital Vibration to which is added a Dictionary of Diseases with suggestions as to the technic of Vibratory Therapeutics with illustrations by Samuel S. Wallian, A.M., M. D. President American Medico-Pharmaceutical League, Ex-President Medica Association of Northern New York, Member New York State and County Medical Societies, Fellow of the American Electro-Therapeutic Association, Member Medico-Legal Society, Associate Editor Medico-Pharmaceutical Journal, etc. Cloth. 210 Pages. Chicago The Ouelllette Press, 1906.

Instead of a preface, the author of this work under the caption, "Non-Prefatory," states that "Prefaces are generally apologies, and to most readers an apology is an impertinence. . . . This is not a preface but a disclaimer." On the next page, he makes his apology and prints his second preface starting "Somewhat heterogeneously thrown together, this little brochure, etc."

The consideration of the subject of "Rhythmic Therapy" is begun with chapters entitled "Non-historic," "Semi-historic." The author states that rhythm is in every case the embodiment and resultant of vibration. . . . Health is a condition or sequence of harmonious vibration, physiologic rhythm. . . . Disease is interrupted, discordant or arrhythmic vibrations. . . ."

If our readers desire to learn more of the author's views on the subject, they are advised to purchase the volume.

**KIEPE'S MATERIA MEDICA AND THERAPEUTICS**. A manual for students and physicians attending post-graduate courses. By Edward J. Kiepe, Professor of Materia Medica in the Department of Pharmacy, and Adjunct-Professor of Materia Medica and Pharmacology in the Medical Department, University of Buffalo. In one 12mo volume of 266 pages. Cloth; \$1.00 net. Lea Brothers & Co. Publishers; Philadelphia and New York, 1906.

This little volume belongs to the *Medical Epitome Series*, on some twenty-three branches of medicine, which the house of Lea Brothers & Co. has been bringing off the press. Kiepe's book, like the others of the series is on the compend style, with questions at the ends of the various chapters. For a rapid review of materia medica and therapeutics, the volume should be of service.

#### THE SIGNS OF THE INTERNAL DISEASE.

With a brief consideration of the principal symptoms thereof. By Pearce Kintzing, B. C. M. D., Professor of Physical Diagnosis and Diseases of the Heart, Maryland Medical College; Physician to the Franklin Square Hospital, Baltimore, Md. Illustrated; cloth; 375 pages. Cleveland Press, Chicago, 1906.

The author has written this book for general practitioners and does not cover internal medicine as comprehensively as have some of our recent books on physical diagnosis, but this is only natural, since Kintzing limits himself almost solely to the signs of disease. The illustrations are good, the print is clear and the text well arranged.

In addition to the space devoted to the methods of physical examinations and their application, excellent chapters on the examination of the blood, the stomach contents and of urine, are added.

**SHOCK AND ITS TREATMENT**. In an article read before the Minnesota State Medical Association, C. R. Curran, M. D., divides the causes of shock into two main classes: the effect of injury or operation on the important nerve paths of the body, and the effect of exposure and injury of the abdominal viscera. All the main nerve paths have a depressor nerve, which, when stimulated, lowers blood pressure, and also a pressor nerve, which, when stimulated, raises the blood pressure. Cold will inhibit the action of the pressor nerve only.

## THERAPEUTICAL HINTS.

It is now universally conceded that GLYCO-HEROIN (SMITH) is the ideal cure for coughs of all varieties. This product embraces the most active sedatives and expectorant agents in the exact proportions in which they exhibit their greatest remedial potency. It matters not what the exciting cause may be, the effect of this preparation is always immediate, pronounced and extremely agreeable. The cough is almost instantly suppressed, the expulsion of the accumulated secretions is stimulated, respiration is rendered free and painless and the inflammation of the lining of the air-passages is speedily allayed by its use.

Dr. Thomas G. Rainey, of Atlanta, Ga., in a recent article states that the combination of drugs, antikamnia and codeine in the form of "antikamnia and codeine tablets," which has been so largely used for the control of cough, is also being successfully employed, to a large extent, in the treatment of nearly all affections of the respiratory tract, which are accompanied by dyspnoea and spasm, namely: bronchitis, laryngitis, phthisis, whooping cough, hay fever and gripal affections.

## THE SUNSET HOUR.

Here on the bouldered cliff the last light dwells,  
Serene and gently somber. Birds are mute,  
Or faintly twittering their soft good-nights,  
Deep in the cañon heart the hidden stream  
Lifts a sweet vesper to the dove-gray sky.

Now in the west the carmine richly glows,  
And lines of amber fire above it stream,  
White golden islands float in that pale sea,  
Of wonder.

Now the still, majestic pines  
Show dark against the halo of the west.  
The blended voices of the insect world  
In peaceful anthem greet the coming stars.

And lo! The maiden moon her silver bow  
Lays on the sun god's now reversed shield,  
While evening holds the mountains to her breast,  
As mothers do their cherished little babes.  
RUBY ARCHER.  
Idyllwild, Cal., Sept. 20, 1906.  
—Daily Times.

To sufferers from indigestion who wish to be cured, it is recommended to eat meat once a day only, chew up completely every mouthful of food, drink eight tumblers of water every day, and no intoxicants—and take as much walking exercise as possible in the open air. This advice has cured many men and women who have given it a fair trial. It is much more efficacious than too much dosing with medicines or pepsin.

A liquid for sanitary spraying, for use in the chambers of the sick, is composed of ten parts of eucalyptol, three parts of thyme oil, as much lemon oil, and the same quantity of lavender oil, in 110 parts of alcohol of 90 deg. To a pint of water add a teaspoon of this liquid.

Medicine is not a rigid system of rules and formulae, as it was in ancient Egypt; a fixed creed to which you are to subscribe, and from which you must not vary. It is a living, growing thing, making use of every resource which the progress of science brings; testing all things and holding fast to that which is good.—Dr. John S. Billings' Address to the Graduating Class, Bellevue Medical College. 1882.

In circulatory disorders, Brown states that strychnine is called for when there is low blood pressure, a rapid heart and bounding and easily compressible pulse; nitroglycerin is indicated when the arterial tension is high, the heart rates low, the pulse full and tense, and the wave very slight.



## METRIC SIGNS.

*French Rules for Abbreviations.*

The French minister of public instruction has decided that all teachers throughout France are in future to employ the following distinctive abbreviations for the various weights and measures: For denoting length—myriamètre, Mm; kilomètre, Km; hectomètre, Hm; décimètre, dam; mètre m; décimètre, dm; centimètre, Cm, and millimètre, mm. For areas—hectare, ha; are, a and centiare, ca or m<sup>2</sup>. For measures of bulk (timber), décastère, das; stère, s or m<sup>3</sup> and decistère, ds. For measures of mass and weight—tonne, t; quintal métrique, q; kilogramme, kg; hectogramme, hg; décigramme, dag; gramme, g; décigramme, dg; centigramme, cg, and milligramme, mg. For measures of capacity—kilolitre, kl; hectolitre, hl; décalitre, dal; litre, l; décilitre, dl; centilitre, cl, and millilitre, ml. The use of the capital letters for the three largest denominations of length are intended to prevent confusion, and all the other abbreviations follow on uniform lines. The employment of full stops between the letters is officially abolished, and k, g, for kilogramme and m, m, for millimètre disappear.

Dr. Thomas (*Fisher's Medical Journal*) believes that, if seen early, ninety-five per cent. of all cases of quincy can be aborted. Aconite and belladonna, if used every twenty minutes for the first six, or three hours, then every thirty minutes for the next eight to ten hours, when it may be lengthened to hourly doses, will arrest the inflammation in from two to five days without suppuration. The prescription will read: R—Aconite, gr.  $\frac{1}{2}$ ; belladonna, gr.  $\frac{1}{2}$ ; water,  $\frac{3}{4}$  iv. Teaspoonful every twenty, thirty or sixty minutes. To be effective, the treatment must be begun at the very beginning of an attack, and a patient who has once had quincy will recognise

the early symptoms, namely the chill, aching of the entire body, and the full, painful throat. If given at this stage it will rarely fail.

**Collusoria.**—The well-known effects of collusoria over venous dilation in the treatment of hemorrhoids has led some to believe that its action extends to the whole venous circulation as well as to that of the personal vessels. Dr. J. D. McCann (*Chicago Medical Times*) reports a case of varix of the vulva during pregnancy which was controlled at will by the internal exhibition of the following: R—Specific collusoria,  $\frac{3}{4}$  i; water,  $\frac{3}{4}$  iv. Mix. Sig: One teaspoonful three or four times a day. Whenever the medicine was withdrawn the varix was aggravated. The remedy was administered for four months.

The steady advance in materia medica, the discoveries and improvements, the developments in chemistry and pharmacy, have been a great boon to the physician, as well as to the laity. No physician can hope successfully to combat disease nowadays, who does not keep pace with the vast strides made by modern therapeutics.

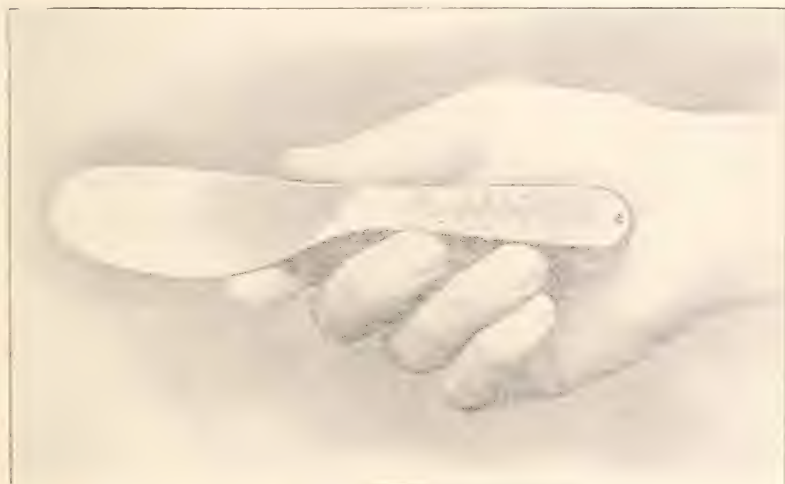
Nelson says probably the best adjunct to the drugs used for their immediate effect upon the heart and arteries is *calomel*. Unload the portal system and accomplish free activity of the kidneys and bowels, and the majority of these cases will be saved.

**Treatment of Shock.** The position with the head down and the foot of the bed raised is of considerable value in the treatment of shock, and should be more extensively used.

It is said that Irid has cured many cases of simple goitre, and exophthalmic goitre and bronchocoele. From two to ten drops is the dose, repeated every three or four hours.

# *Antiphlogistine*

(Inflammation's Antidote)



## THE SPATULA

oftentimes will make unnecessary

## THE SCALPEL

if it be used for the application of Antiphlogistine hot and thick in the various inflammatory and congestive conditions.

# ANTIPHLOGISTINE

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Her temperance over Appetite, to know  
In measure what the mind may well  
contain,  
Oppresses else with surfeit, and soon  
turns  
Wisdom to folly, as Nourishment to  
Wind.

—John Milton.

It is recommended not to give *ergot* until after the third stage of labor unless the placenta and secundines are entirely free. It is reasonable to suppose that the contractile power of *ergot*, if it be given before this time, will close an opening that is most needed for the delivery of the afterbirth.

Curran says every operation over an hour and a quarter long tends to produce *shock*. It is better to put our patient to bed without shock than to be too careful over the little niceties of technic. It is better to do two operations than to subject a patient to this dangerous condition.

*For relief of intercostal pain* Dr. Reid recommends sterile water injections. Localize the pain by pressing deep into the intercostal space, then inject a syringeful of sterile water into the tissues in the vicinity of the nerve. Complete cure has followed this procedure when morphine gave only temporary relief.

**HEROIC TREATMENT FOR WARTS IN ELDERLY PERSONS.** Nothing is more dangerous than to attempt the removal of warts in elderly persons with the milder caustics, such as nitrate of silver, for this will often supply the stimulus which leads to their transformation into epitheliomata. They are best eradicated by the dermal curette, by strong caustic, electrolysis, or if they are large, by excision.

The milder and safer the remedies we employ, the more successfully do we

restore the patient's health. The knowledge of materia medica is simply the material; it may properly be said that any agents, or any instruments employed to combat and cure diseased conditions come under the head of materia medica.

*Colchicum* in minute doses will be found a prompt remedy in *persistent vomiting*, usually that caused by disorder of the stomach or bowels, especially that of cholera infantum.

Never advise an elastic stocking in cases of varicose veins where thrombosis exists. The pressure may detach a part or whole of the thrombus, propelling it into the general circulation.

*Cannabis indica* may be said to be a true *sedative to the stomach*, without causing any of the inconveniences experienced after the administration of opium, chloral or the bromides.

*Varicose Veins.* Lift the vein with a fold of the skin and inject twenty drops of tincture of hamamelis behind, under the vein; one injection is said will usually be sufficient to produce a cure.

Sodium salicylate is a most efficacious drug in cases of *tonsillitis*, meeting the *rheumatic diathesis*. Gargles are applicable, both as a gargle, and as a constitutional remedy.

A tablespoonful of turpentine in a half pint of water, kept simmering over a lamp, is a splendid adjuvant to other therapeutic methods in *bronchitis of children*.

In *tonsillitis* equal parts of benzoic acid and sodium salicylate applied to the tonsils is a new and serviceable remedy, applying two remedies given in one, but in a different way.



Strophanthus has been prescribed in several cases of *goitre*, ten drops of the tincture three times daily, with a rapid reduction in the size of the enlargement, and in every case a cure.

*Nux vomica* is said to be specific in *atonic dyspepsia*; if there is *achlorhydria*, hydrochloric acid must be given with it.

To sterilize milk, support the bottles containing the milk in a vessel of water. When the water reaches 167 degrees F. draw the vessel to a cool part of the stove and let it remain for twenty minutes. Then remove the bottles and keep in a cool place.

For cracked nipples, brush them once a day with tincture chloride of iron. The results will surprise you and you will have one on the old moss-back doctor who carries nothing but a lump of gum opium and a few c. c. pills.

For toothache nothing is better than oil of cloves and tincture opium, equal parts, applied to the aching tooth on a pledget of cotton, says Dr. J. L. Fennel.

Tannate of pelletiereine is a good remedy for *tenia solium*. The dose is 5 grains. The instructions to the patient are the same as with other anthelmintics.

In chronic ankylosing catarrh of middle ear Dr. Bishop employs air massage of the drum head, in alternation with injections of lavolin into the middle ear.

Yohimbin, an alkaloid derived from an Indian tree—the Yohimbene tree—and is said to be a valuable agent in sexual impotence, in doses of gr. 1-12 t. i. d.

For vertigo with hyperesthesia of scalp and headache Dr. Hare recom-

mends fluid extract of ergot, 20 drops, and potassium bromide 5 to 10 grains, t. i. d.

During after-pains a combination of morphine and atropine may be used and chloroform if necessary. Codeine, cimicifuga and gelsemium also give relief.

Benzoate of soda, on account of its solubility, is preferable to benzoic acid and in 10 to 20 grain doses it frequently gives good results in cystitis.

Nitrate of silver in solution, painted over the tonsils in tonsillitis, will abort some cases, but to be effective it must be applied early in the disease.

Dr. Stern has used formic acid with benefit in cancer, and thinks it has certainly delayed the fatal issue in a number of inoperable cases.

*Cactus grandiflorus* should be used in from one to three minim doses, four times daily in the hot flashes common to women at the menopause.

Acetic acid brushed in a line over a *plaster of paris bandage* will render it soft, and in a few minutes it may be cut with an ordinary knife.

To remove moles apply with a splinter of wood a small quantity of acid nitrate of mercury, carefully avoiding the sound skin.

*Hay Fever*. An infusion of ragweed has been recommended in the treatment of this disease. Physicians who have used it claim but very few failures.

A good *local anaesthetic* for spraying abscesses before lancing is made with half a drachm of chloroform in an ounce of ether.



For moistening sheets used in isolating sick-rooms with contagious cases, and for towels to be used in deodorizing, "Platt's Chlorides" is particularly adapted, as the Zinc and the Lime Chlorides it contains, being highly deliquescent, the sheets and towels may be kept moist longer than by any other antiseptic solution.

"Platt's Chlorides" is an odorless, colorless liquid disinfectant and deodorizer; powerful and safe. It is sold in quart bottles only by druggists everywhere. Diluted with ten parts of water for moistening sheets and for general use it costs less than five cents per quart.

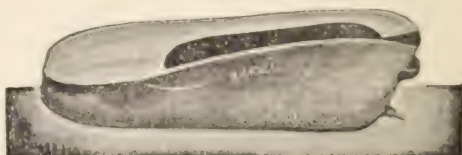
*Formula* — A combination of the saturated solutions of Chloride Salts proportioned as follows: Zn 40 per cent., Pb 20 per cent., Ca 15 per cent., Al 15 per cent., Mg 5 per cent., K 5 per cent.



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# SOUTHERN CALIFORNIA PRACTITIONER

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DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,  
Associate Editors.

## THE PUBLIC HEALTH OF OUR CITY DURING THE LAST FIVE YEARS.\*

By GEORGE H. KRESS, B. S., M. D., Los Angeles, Cal.

The public health of any section should be to its inhabitants, and to its physicians always is, a matter of considerable interest.

In considering the health of any community the climatologic and sociologic conditions are the underlying elements on which the morbidity and mortality of that community may be said to depend. We of Los Angeles for instance, who live in a region so endowed by nature in its physical environment that its salubrity and beauty are known the world over, would naturally on that account, expect to be confronted with morbidity and mortality statistics far below the figures of cities not so well favored by nature. When the absence of seething industrial life and the unhygienic home conditions that nearly always are to be found in congested manufacturing centers is also taken into consideration, the temptation to look for only small amounts of sickness or death in this community, is correspondingly increased.

A study of local statistics shows, however, that the morbidity and mortality figures of our city are, as a class, higher

than those of the remainder of the country. Thus, for instance, the average death rate from all causes per 100,000 population in Los Angeles, for the years 1900 to 1904 inclusive is 1,920, while the average death rate from all causes per 100,000 population in the registration cities of the country was 1,750. In other words there were about 170 deaths more to the 100,000 population from all causes of death in Los Angeles, than there were in the registration cities of the country, the registration cities being those in which the mortality statistics are most accurately kept; the health offices and sanitary supervision in those cities, being in addition, generally of the highest efficiency.

Diagram IV brings out in graphic fashion a comparison of the death rates from all causes per 1,000 population in Los Angeles, and other portions of the United States.

These higher mortality rates holding true for Los Angeles, when the physical environment and the sociologic conditions should really point to lower figures,

\*Read before the Los Angeles County Medical Association. October 5, 1906.



**TABLE I.**  
**DEATH RATES FROM CERTAIN SPECIFIED CAUSES.**

Per 100,000 Population. For U. S. Registration Area and Los Angeles (5 Years).

CAUSE OF DEATH		Regis- tration Area Total	Reg. Area Cities	Reg. Area Rural	Los Angeles Average For 5 Years	L. A. Year 1900	L. A. Year 1901	L. A. Year 1902	L. A. Year 1903	L. A. Year 1904
1	All Causes	1660	1750	1430	1923	1871	1983	1964	2271	1528
GENERAL DISEASES										
2	Typhoid	33.8	36.3	27.8	38.4	37	38	39	45	33
3	Malarial Fever	5.6	6	4.7	3.2	2.9	1.9	1.6	.7	2
4	Small Pox	3.7	4.6	1.5	0	0	0	0	0	0
5	Measles	10.1	11.1	7.7	3.8	4.8	9	3.3	7	3
6	Scarlet Fever	11.8	13.8	7	8.3	6.8	4.9	10	17	3
7	Whooping Cough	11.3	12.2	9.1	10.5	20	19	5	8	5
8	Diphtheria	33.7	39.2	20.1	34	31	45	38	35	21
9	Influenza	20.8	17.3	29.3	19.2	18	15	14	11	8
10	Cholera Nostris				2			8		5
11	Dysentery	9.1	8.7	11	6.5	4.8	6.8	5	11	5
12	Erysipelas				5.9	8.7	2.9	3	11	4
13	Other Epidemic Diseases				7	9	9	0	2	0
14	Septicaemia				19.2	21	15	16	25	18
15	Tuberculosis (Total)	195			104.2	389	437	110	474	311
16	(Lungs)	172.6	190.3	129.3	369	361	392	302	442	288
17	Larynx	1.6			3.6	9	4.9	2.5	5	5
18	Meninges	8.7			13	13	19	18	8	7
19	Abdominal	5.8			9.7	8.7	12	11	10	7
20	Potts	1.5			1.5	1.8	9	8	3	1
21	Abscess	2			0	0	0	0	0	0
22	White Swelling	5			7	0	9	8	2	0
23	Other Organs	1.3			2.1	8	1.9	4	2	2
24	General	2.6			3.7	1.8	3.9	9	1	3
25	Serofula				3	0	0	8	7	0
26	Venereal	1	4.9	1.7	3.2	2.9	1.9	4	1	3
27	Cancer	66.6	67.4	64.6	94.4	90	108	99	108	67
28	Tumor				1.6	8	2.8	1.6	2	1
29	Rheumatism	9.1	9	9.4	9	10	13	11	5	6
30	Diabetes	11	10.6	11.7	12.3	11	18.7	18	17	7
31	Anaemia				6.9	2.9	10	5	12	5
32	Alcoholism	6.2	7.3	3.4	12.4	16	15	11	8	12
33	Chronic Poisonings				5	0	1.9	1.6	0	0
34	Other General Diseases				2.2	2.9	2.9	3	2	5
NERVOUS DISEASES										
35	Encephalitis				1.8	2.9	2.9	8	2	5
36	Meningitis	33.1	36.6	34.6	46.1	41.5	36	47	64	42
37	Apoplexy	69.2			72.8	66	100	75	66	57
38	Softening of Brain				5.7	6.8	4.9	5	7	5
39	Paralysis	21.9			26.5	29	5.19	32	34	18
40	Epilepsy				2.2	2.9	1.9	1.6	2	3
41	Convulsions				11.7	13	5.8	13	13	14
42	Other Dis. of Nervous System				31.2	35	38	27	35	21
CIRCULATORY DISEASES										
43	Pericarditis				2.6	3.7	3.7	8	2	3
44	Endocarditis				13.6	9	3.12	17	28	22
45	Heart Disease	120.9	116.5	131.6	123.4	118	124	122	148	105
46	Angina Pectoris				10.7	6.8	13	7	20	7
47	Embolism and Thrombosis				8.5	6.8	10	10	10	6
48	Other Circulatory Diseases				20	20	16	20	28	16
RESPIRATORY DISEASES										
49	Laryngitis				1.1	2.9	9	0	1	1
50	Acute Bronchitis	39.5	43.8	28.8	14.4	14	12	18	18	10
51	Chronic				12.6	9	3.10	15	16	10
52	Broncho-Pneumonia				22.6	25	25	25	23	15
53	Lobar Pneumonia	134.9	149.3	99.7	133.4	144	149	148	155	101

TABLE I—Continued.  
DEATH RATES.

CAUSE OF DEATH				Regis- tration Area (Total)	Reg. Area Cities	Reg. Area Rural	Los Angeles (Average) For 5 Years	L. A. Year 1900	L. A. Year 1901	L. A. Year 1902	L. A. Year 1903	L. A. Year 1904
54	Pleurisy.....						6.3	8.7	4.9	7	6	5
55	Congestion of Lungs.....						14.4	12	11	20	14	5
56	Other Diseases of Resp. System ..						16.2	18	20	20	10	13
DIGESTIVE DISEASES.												
57	Tonsilitis.....						2.1	1.8	0	8	1	0
58	Diseases of Stomach.....						22	27	24	20	23	16
59	Diarrhoea and Enteritis.....	113.1	126.4	80.2			53	66	48	78	76	47
60	Hernia and Intestinal Obstruction.....						12.2	10	12	10	16	13
61	Cirrhosis of Liver.....	14.1	16	9.4			14.6	14	11	19	14	15
62	Other Diseases of Liver.....						10.7	4.7	14	14	10	11
63	Peritonitis.....	12.1	12.5	10.9			27	40	30	11	31	23
64	Appendicitis.....	10.6	12.2	6.7			13.8	13	14	15	15	12
65	Other Diseases of Digestive Sys.....						6.3	5.7	7.8	8	7	3
GENITO-URINARY DISEASES												
66	Acute Nephritis.....	94.6	104.8	69.6	8.0—	112	104—	4.7	5.7	7	17	6
67	Bright's Disease.....							90	138	100	117	75
68	Calculi of Urinary Tract.....						3	0	9	0	7	0
69	Uterine Tumor.....						2.9	8	2.9	4	2	5
70	Ovarian Tumor.....						.8	0	5	.9	2	.7
71	Other Dis. of Gen.-Urinary Sys.....						15	15	18	10	17	15
CHILDBIRTH												
72	Puerperal Septicaemia.....						2.3	7	6	3	1	1
73	Other causes due to Childbirth.....						4.2	2.7	7	8	7	3
SKIN DISEASES.												
74	Diseases of Skin.....						8.0	9.2	10	5	8	8
LOCOMOTOR DISEASES.												
75	Diseases of Locomotor System.....						1.7	1.7	9	4	2	0
MALFORMATIONS.												
76	Malformations.....						7.9	13	5.7	12	7	2
EARLY INFANCY.												
77	Premature Births.....						40	39	21	27	18	15
78	Congenital Debility.....						31.8	37	16	34	42	30
OLD AGE.												
79	Old Age.....						43.8	31	41	40	52	55
VIOLENCE.												
80	Suicide.....	104.3	112.4	84.5	28.6—	137	108.4—	16	19	37	14	27
81	Other Violence.....							93	102	110	145	92
ILL-DEFINED CAUSES												
82	Ill-Defined Causes.....						42.6	54	32	25	62	40

an inquiry into the cause of this unusual state of affairs is in order.

It is not necessary to discuss at length the physical environment of this region in which we dwell, for with so well drained a soil and such an abundance of sunlight and oxygen, it needs no argument to defend its salubrity.

This being so, only the sociologic phase of the problem remains to be investigated. The general industrial conditions in this city do not, as a class, favor an undue amount of illness and death, the crowded Mexican, Russian and lodging-house quarters being the major exceptions.

If the existence of an excessive amount of disease is then opposed to the conditions of Los Angeles which exist from within, whence does our excess in mortality come? It comes from without; in other words, much of our mortality is to be traced to persons who acquire the diseases which cause their deaths, in other portions of the country. Many of these persons come to Los Angeles in the hope of regaining their health, but as they are unfortunately, often afflicted with incurable conditions, recovery does not reward their journey to the land of the flowers, and dying here, their deaths are added to our mortality tables, and

our death rates are correspondingly increased. Tuberculosis is a disease in point.

But even this acknowledged influx of disease-stricken health seekers is insufficient to fully account for the high death rates referred to. Paradoxical though it may seem, our higher Los Angeles mortality rates are due not only to the influx of the large number of disease-afflicted persons, but, also to the arrival hither of even a many times larger number of very healthy persons.

This seeming anomaly is due to the conservatism and honesty of our health officer, and is explained as follows:

The annual increase to our population, of thousands of active healthy persons from the East, is responsible for higher statistical death rates because our health officer, in order to be conservative, is at the present time keeping the total population figures on which he bases his his rate averages, about 25,000 persons less than our real population. As an example, at the present time the death rates are based on an estimated population of 200,000 when there is but little doubt that we have at least 230,000 permanent residents and in addition some ten or twenty thousand transients. Here then, we note an actual variation in population figures sufficient to institute a new city of almost fifty thousand persons.

An additional factor, of lesser importance, is the fact that all the deaths of the County Hospital, which institution is located within the Los Angeles city limits, are credited to our city's mortality. The County Hospital however receives patients from a territory having an additional one hundred and fifty thousand more persons, so that one-third or about 100 of the total annual deaths of that institution should be really not credited to the city of Los Angeles.

Because of these reasons the Los Angeles death rate from all causes, should really be lower than the average

of the registration area of the United States.

But even counting the increase due to influx of hopelessly ill people from the East, and of County Hospital mortality of persons from without the city, and the conservatism of our health officer in not using the entire probable population as a basis of computation for rates, there is only an excess in the death rates for Los Angeles, over the registration area average, of only two persons in the thousand, an excess so low as to prove almost in itself our first contention that Southern California was so well favored by nature that there would be here, under normal local conditions, a far less amount of morbidity and mortality than is to be found in the East.

Before leaving the subject of the estimated population and generally accepted mortality rates of our city, it may not be out of place to call attention to some facts concerning the manner in which the mortality data of Los Angeles appear in the latest report of the United States Bureau of Census, which has recently come off the press.

The census of 1900, the twelfth which our country has taken, was compiled under the direction of a bureau organized a short period before that time. This mode of procedure had been the usual custom, a special act by Congress, being necessary to authorize the taking of a decennial census.

In 1902, with the creation of a Department of Commerce and Labor, the Census Bureau of the United States was put on a permanent foundation, and as regards the reports relating to vital statistics, such reports were authorized to be published yearly. Owing to the difficulty in getting the work on a systematic basis, the reports for 1900 to 1904 have only recently come off the press, in a massive volume of some seven hundred pages, although hereafter annual reports will appear.

The information contained in this



volume is of great value and interest, but the value to Los Angeles is greatly minimized, because our city figures in only four brief pages, whereas other cities of over 100,000 population are mentioned again and again in different tables. The writer of this paper addressed the Director of the Census as to why this was so, and was told that the Bureau's population estimates were so at variance with the city's own figures, that its commercial bodies objected to the publication of rates based on the Bureau's calculations as to population.

The Bureau is forced naturally to adopt some method of estimating the increase of population between the regular decennial census years and after careful study of the subject decided that "the annual addition of one-tenth of the numerical increase between 1890 and 1900 most closely approximated" the probable increase of population in the intercensus years of the present decade. Or to give a concrete example of how the Bureau's rule worked, Los Angeles would each year add to the population of 102,000 which it had in 1900, one-tenth of the total increase of the preceding ten years, i. e., would add yearly 5,200 persons to its population, giving us a total population in 1906 of

131,000 persons, or about 100,000 less than the city actually possesses.

This estimate of population would double our mortality rate, so that in place of the rate of 19.2 deaths from all causes per 1,000 population as already noted, Los Angeles would have a rate of 38.4 deaths from all causes per 1,000 population, as against the registration cities rate of only 17.5 per 1,000 population. Such an excessive mortality is so grossly at variance with actual conditions that even the Census Bureau hesitated to publish the figures.

A reflection of the Census Bureau's method of estimating the population of Los Angeles was evidenced in the recent educational number of the *Journal of the American Medical Association*, where, under a discussion of the clinical facilities of our city Los Angeles was credited with a population of only 116,000 instead of the more correct figure of 250,000.

Whether any special effort to have the Census Bureau credit Los Angeles with a population more in accord with actual conditions, should be made, is a question, since it is doubtful whether the Department of Commerce and Labor would abrogate its general rule in favor of a special instance. It certainly is most unfortunate that a city of the

TABLE II.  
SOME LOS ANGELES MORBIDITY AND MORTALITY FIGURES

YEAR	BIRTHS			Cor- oner Cases	SMALLPOX		TYPHOID		Diphtheria		SCARLET	
	Total	Still	Prem.		Sick	Fatal	Sick	Fatal	Sick	Fatal	Sick	Fatal
1900	1448	29	39		33	0	287	47	221	34	184	6
1901	1702	48	48	213	90	0	220	33	237	18		
1902	1973	70	39	273	128	0	311	44	254	36	493	
1903	2336	75	66		112	0	296	53	528	49	996	22
1904	2906	76	99	328	22	0	272	54	872	57	205	7
1905	3155	139	81	462	49	0	223	54	548	37	144	2

250,000 class should be barred from a proper recognition in the very many valuable statistical tables published in the Vital Statistics of the Census Bureau.

It would seem to be the duty of this Los Angeles County Medical Association, which more than any other organization in the community should take a real interest in the Vital Statistics of the city, to look into this matter, and if possible, obtain for our city in these valuable Census Bureau reports a proper place and just recognition.

Let us consider now some of the information contained in Table I. This table gives the death rates from various diseases per 100,000 population for not only the city of Los Angeles for five different years, but the average for the entire five years, and it shows further how Los Angeles rates compare with

those of the rural, the city and the total Registration Area rates of the United States.

For all causes of death the Los Angeles rate exceeds the Registration Area rate by 263 deaths per 100,000 population. It will be noted that the 1903 Los Angeles rate exceeded the Registration Area rate by 611 deaths per 100,000 population probably owing to a change in the estimated population on which the rate was based.

Our typhoid rate for some reason is in excess of the Registration Area rate, although the prevalent impression is, that we have a very pure water supply. The malaria rate is less than for the Registration Area, and yet in excess of what the physical environment would lead us to think should exist.

Small-pox is worthy of special note. By reference to Table II, it will be seen that in five years there have been 434

### TABLE III. DEATH RATES

AT EACH SPECIFIED AGE FROM ALL CAUSES, AND FROM TUBERCULOSIS, PER 100,000 POPULATION

LOS ANGELES	AGE															
	All Ages	Under 1	1-2	2-3	3-4	4-5	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54
Year 1900	1871	253	37	23	20	15	51	81	225	240	231	222	214	181	62	5
" 1901	1983	142	25	25	17	14	24	93	260	292	272	246	240	214	88	13
" 1902	1964	215	50	26	11	13	54	92	233	261	237	230	234	191	88	6
" 1903	2271	225	55	31	30	11	66	104	282	326	293	258	277	209	81	9
" 1904	1728	151	24	13	15	8	33	82	207	205	198	176	181	157	56	6
Average For Five Years	1923	197	38	23	18	12	45	90	241	264	246	226	229	190	75	7
Registration Area	1636	138	80	36	23	17	47	70	141	145	138	148	171	164	86	13
All Causes																
Registration Area (Total Tuberculosis)																
1904	166	2	1	7	5	3	1	25	68	40	23	14	11	4	1	2
Los Angeles (Tuberculosis lungs only)																
1904	288	5	1	5	5	0	2	23	91	66	54	27	13	4	2	0

cases of small-pox in the city and yet not a single death therefrom, a tribute, not only to compulsory vaccination of all school children and suspected adults, but to the vigilance of our Health Department.

The next disease in Table I, measles, brings out a curious contrast to the small-pox figures. Small-pox, dreaded by the laity, as if it were the plague, and a notifiable disease, is credited with not a single death, but measles, insignificant measles, not deemed worthy of being placed among notifiable diseases—measles is responsible for 3.8 deaths per 100,000 population.

The scarlet fever rate is slightly below the Registration Area figures.

Whooping-cough on the contrary, almost equals the Registration Area rates and is certainly higher than this equable climate would suggest.

The diphtheria rates are much lower than formally, owing to the earlier use and larger dosage of antitoxine. Our

diphtheria morbidity, when it has not been due to an infected milk supply, has been noted to have a curious relation to our Santa Anas or dry summer dust storms.

The influenza rate also seems unduly high.

Tuberculosis is no surprise. The wonder is not, that Los Angeles should have a rate of 404 as against 195 for the Registration Area, but rather that it should not be much higher than this. The excess seems to be confined solely to pulmonary tuberculosis, the rates for laryngeal and other forms being less than the Registration Area figures.

Since writing the above, an interesting side light is thrown upon the tuberculosis statistics in the tables referred to elsewhere, by a comparison with the mortality figures from this disease as given in Table V, for the year that closes December 1st, 1906. Our Health Officer's report has the following to say concerning this disease:

TABLE IV.

<u>AREA.</u>	NUMBER OF DEATHS FROM ALL CAUSES PER 1,000 OF POPULATION: 1900 TO 1904.					
	ANNUAL AVERAGE	YEAR 1900	YEAR 1901	YEAR 1902	YEAR 1903	YEAR 1904
LOS ANGELES	19.1	18.7	19.8	19.6	22.7	15.0
REGISTRATION TOTAL AREA	16.0	17.6	16.6	16.0	16.2	16.7
REGISTRATION CITIES	17.5	18.6	17.4	17.0	17.1	17.6
REGISTRATION RURAL.	17.3	15.2	14.6	13.4	13.8	14.5



"There were 269 living cases reported to the office during the past year, and 734 deaths. Of those 52 were Natives, 30 came from other parts of the Pacific Coast and 643 from eastern points. 76 had lived here less than 3 months, 132 less than 6 months, 189 less than 1 year and 434 under 5 years. The discrepancy between the number of living cases reported and the number of deaths is due to the fact that physicians do not report their tuberculous cases.

"The enforcement of the anti-expectorating ordinance, the fumigation of all rooms or houses in which tuberculous patients have lived or died, the sanitary inspection of tenement and lodging houses and the compulsory notification of cases by physicians, all of which are provided for by an ordinance now before the City Council, it is hoped will reduce our mortality from this disease.

"Many incipient cases would recover, and many cases now doomed to contract the disease would never be infected if the city and county would provide a suitable accommodations for this class of patients.

"There were 3740 deaths from all causes reported to the office during the year.

"Estimated population 250,000. Death rate 14.96 per thousand."

The Los Angeles cancer rate of 94 as against 66 for the Registration Area is also startling. The disease is certainly not indigenous here and the rate must be due to the influx of cases from elsewhere.

It seems astonishing also that there should be twice as much alcoholism mortality here as in the Registration Area. We certainly as a city, do not consume twice as much alcohol as cities of like size, and I cannot account for the excessive rate.

Under the respiratory diseases, the pneumonia figures are of considerable interest. It is hard to believe that we have here as much lobar pneumonia as

in the Registration Area, and yet that is the verdict of these figures. No doubt some of the mortality credited to this disease is tuberculosis, for not infrequently physicians, out of deference to the feelings of a patient's family, will give some other cause of death than tuberculosis.

The low rate from diarrhea is a reflex of our good water, milk, and food supplies, and of the excellent summer climate of the region. Especial credit is due, however, to the efforts of our Health Officer to maintain the purity of water, milk, and food supplies.

The excessive peritonitis and appendicitis mortality, I cannot understand. No probable indigenous causes suggest themselves to me, unless it be a more refined diagnostic acumen on the part of our surgeons, or a fame for successful operative work so great as to lead patients to come hither from far and near.

Our nephritis rates are increased by the influx from the East of this class of patients.

That there should be more deaths from violence here, is also seemingly out of harmony with the environment. The magnificent rapid transit system, which we both demand and admire, is not without its disadvantages, one of the most important being the frightful loss of life connected therewith. The suicide rate is in part accounted for by the fact that with our many health seekers come many despondent individuals, to whom life stands for little other than physical and mental misery, and in desperation, some of these put an end to existences so miserable, that death seems heaven. This same cause may also account for some of our alcoholic mortality.

Turning now to Table II, under the first three vertical columns, we note under births, that though the population of the city was increasing in tremendous bounds, the number of still born children was approximately the same for about three years.

The increase in coroner's cases is a tribute to deaths by violence and to deaths from starvation, tuberculosis or kindred diseases, of penniless invalids from the East.

Our typhoid death rate is higher than the rate of the Registration Area. Table II shows the relation between the typhoid morbidity and mortality.

In 1900 there were 221 cases of diphtheria with 34 fatalities, and in 1905, with more than twice as many cases of this disease, there were only 37 deaths, which decreased mortality as already stated, is largely due to the early use of diphtheria antitoxine in large dosage.

The varying proportion of deaths from scarlet fever is of interest.

Table III presents the death rates from

all causes of death at different age periods for five different years and for the entire period, and compares the average rate for Los Angeles, with the Registration Area figures for the same time. Comparing the five year period figures in the horizontal columns between the black rules we note that up to the age of ten—in infancy and early childhood—the Los Angeles rates are below those of the Registration Area, a reflex of an excellent climate permitting the out-door life the year round, and of pure water and food supplies.

Between the age of 20 and 80, however, the Los Angeles are higher than the Registration Area rates, this excessive mortality being due to the large number of invalid adults who

TABLE V.

## SUMMARY OF DEATHS FROM TUBERCULOSIS IN LOS ANGELES FOR YEAR ENDING DEC. 1, 1906.

	Total	Nativity				Length of Residence							
		Natives	Pacific Coast	Other Parts	Total	Less 3 Months	3-6 Months	6-12 Months	1-5 Years	5-10 Years	Over 10 Years	Life	Unknown
DECEMBER	76	4	4	68	76	12	4	9	22	5	16	4	4
JANUARY	73	4	4	65	73	6	8	4	22	5	20	4	4
FEBRUARY	62	6	4	52	62	10	6	7	14	5	8	6	6
MARCH	69	3	1	65	69	5	10	5	17	5	22	3	2
APRIL	62	2	6	54	62	4	4	2	24	5	15	2	6
MAY	69	6	—	63	69	2	7	5	28	5	9	6	7
JUNE	61	10	6	45	61	3	4	4	17	6	14	10	3
JULY	56	3	5	48	56	9	4	6	21	6	7	3	0
AUGUST	53	4	4	45	53	5	1	7	17	8	9	5	1
SEPTEMBER	36	2	2	32	36	11	3	3	13	0	3	2	1
OCTOBER	48	2	1	45	48	3	0	3	17	9	13	2	1
NOVEMBER	69	6	2	61	69	6	5	2	33	3	12	6	2
GRAND TOTAL	734	52	39	643	734	76	56	57	245	62	148	43	37

come to Southern California and die here. The last two horizontal columns of this table, relating to tuberculosis, the mortality rate from which disease, gives the tone to all our local rates, brings out the same fact, for after the age of 20, the tuberculosis rates are virtually twice as great as those of the Registration Area.

Table IV is a diagram dealing with the rates from all causes of death in Los Angeles, and with the rural, city and total United States Registration Area rates in five different years and for the entire periods. The first column brings out the point that in spite of a most excessive mortality dependent upon conditions not indigenous to the physical environment or to the mode of living of our people, our rates for all causes are but little in excess of those of the United States. This is indeed a tribute to the beneficent climatic environment of this section of our country, but the effort should constantly be, not to be satisfied with so good a showing, but to make it better.

Did time permit, it would be possible to draw many other interesting conclusions from the figures presented.

\* \* \*

#### REMARKS OF DR. KERRY FAIR.

DR. GEORGE L. FAIR—For the Society was induced in the context for the presentation of those interesting statistics and recognized at what was said as to the climatic environment of Los Angeles being opposed to much morbidity or mortality. And if our morbidity was excessive in amount, it was probably due to the reasons enumerated by the speaker, and the fact that with the real rainfall other than in this country, some a large amount also of neuritic influences.

The statistics of my present health sufferer, however, in making a free estimate of our population was in strong contrast to the position taken by a health officer of years ago who not only overestimated the city's population, but ruled out most of the County Hospital and deaths due to tuberculosis as not really belonging to the city. The heavy proportion of deaths due to violence was explainable, perhaps because Los Angeles was one of the jumping-off places of the country and immigrant individuals of all parts of the country congregated here. Street car accidents no doubt played a role but this was

partly our fault in demanding such rapid service, and also because the material prosperity in this country was so great that able bodied men could earn more money in other work than in street cars, so that the railway was forced to take inferior men as motormen.

\* \* \*

DR. HARRIS GARFIELD—The reasons given by Dr. Kees for the greater rates were no doubt the correct ones. Would add one other factor, that due to the fact that the hospitals and surgeons of Los Angeles were accepting a more than local population, so patients came here from all parts of the country and especially from Old and New Mexico, Arizona and other parts of California.

As to the typhoid rate, the figures for that disease were lower than for any other large city, and such cases as did arise came not from drinking water, only a few from milk, but most from vegetables that had been irrigated by the city's sewage. This evil the Health officer had fought, but had been unable to abolish, since the Board of Public Works were the responsible parties in securing the sewage right to irresponsible parties.

The low death rate among infants was a tribute to the inspection of the dairies by the Health Officer.

The low present death rate from diphtheria as stated, is due probably to the fact that antitoxin is given at the time outbreaks are seen or for diagnosis and the fact that the presumptive diagnosis is more careful and appropriate treatment instituted. The large number of deaths from diphtheria and pertussis, its probably have their explanation in Los Angeles growing food as a sugar center, and many well-known foreign cases come here for operation. The tuberculosis conditions are well known, in addition to anticipating or eliminating we should have compulsory registration or fumigation and proper inspection of houses and lodging houses.

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DR. F. M. FORTENBACH—Believed that many of the deaths attributed to pneumonia are really due to tuberculosis. Thinks the tubercular rate should be lower. Pneumonia much morbidly is also surprising. Many of the deaths are probably tuberculous individuals with toxemia dependent. Perhaps the tubercular deaths are increased by the fact that tuberculous patients in decreasing consciousness resort to alcoholism in desperation.

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DR. HENRY HERBERT—Was rather surprised that under the conditions enumerated the rate from all causes should really be as low as it is. Would be tempted almost to say that half of our increasing population was afflicted with either acute or chronic tuberculosis. The climate of Southern California is so well advertised that it is known all over the world and cases of lung, kidney and heart disease and rheumatism come to us from



everywhere. In lung trouble, Denver sends us most of her hemorrhagic cases.

Certain diseases seem to be endemic here. Perhaps more rheumatism and arthritis. Perhaps gastro-intestinal disturbances also. He had noted a peculiar form of hives or urticaria.

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DR. THEODORE DAVIS—The large number of pneumococci in the sputum from respiratory disease had been a surprise to him.

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DR. F. C. E. MATTISON—Lobar pneumonia at times is almost never seen and then an epidemic prevails. Had seen it only during last three or four years.

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DR. GEO. L. COLE—Had had treated cases of lobar pneumonia every year during last ten or fifteen years.

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DR. A. L. KELSEY—Recalled an epidemic of true lobar pneumonia about eighteen years ago.

DR. F. M. POTTENGER—Desired to make a motion if it was in order, for the appointment of a Committee, as suggested by Dr. Kress, that would communicate with the Department of Vital Statistics of the United States Census Bureau, so that in the future our city would receive proper representation in the Bureau publications.

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DR. F. C. E. MATTISON—This motion would not be necessary as the Secretary of the Association would notify the Committee on Public Health consisting of Doctors Cole, Black and Beckett to communicate with the Census Bureau in regard to this matter.

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DR. GEORGE H. KRESS—Had nothing more to add, only was desirous that the Association should take such action as would give the city of Los Angeles such representation in these valuable statistical tables as were its just due.

## ALTITUDE AND PNEUMONIA.\*

BY ISAAC W. BREWER, M. D., FORT HUACHUCA, ARIZONA.

In a previous paper (1) sixty-one cases of lobar pneumonia were reported from three military stations in Arizona and New Mexico that had an elevation of more than 4,500 feet. A study of those cases seemed to indicate that altitude had very little to do with the mortality, but the number of cases was too small to warrant any definite conclusions. In this paper are presented the statistics of lobar pneumonia for the entire army for the period from July 1st, 1870, to June 30th, 1874. These data are taken from *Circular Number 8* of the Surgeon General's Office, 1875, and are as comparable as is usual with such statistics, but there was considerable difference in the sanitary surroundings of the soldier at different stations. The troops on duty east of the Mississippi river and on the Pacific coast were doing the usual garrison routine, while those portions of the army stationed west of the Mississippi were in the field during a considerable portion of the time. Their

barracks were often temporary structures and were frequently overcrowded.

The type of building recommended at that time, for barracks, provided an air space of 500 cubic feet per man. The ventilation was often very imperfect and at many posts the air space was much less than 500 cubic feet.

This condition may have influenced the spread of the disease, but as with but few exceptions all the sick were treated in the hospital where a much larger air space and better ventilation was provided, it probably had no influence upon the mortality.

Assistant Surgeon John S. Billings (2) in discussing the vital statistics of the army for the period under consideration says: "The mortality from disease among these picked men (the soldiers) is distinctly greater than among men of the same age in civil life under the same climatic conditions."

The statistics here presented are for a mean strength of 24,349 men. There

\*Written for the Southern California Practitioner.

were during the period 768 cases of lobar pneumonia with 114 deaths, a mortality of 14.9 per cent. Six hundred and seventy-three cases were amongst the white soldiers, eighty of whom died, a mortality of 13.2 per cent. Amongst the colored troops, all of whom were serving south of the 40th parallel, there were 95 cases with 25 deaths, a mortality of 26.3 per cent. The mortality amongst the white troops serving south of the 40th parallel was 13.9 per cent.

In Table I the cases of pneumonia have been arranged in groups for every five

hundred feet from sea level to an altitude of 8,000 feet. It shows that the greatest admission rate was 13.77 per thousand between the elevations of 1,001 and 1,500 feet. The lowest admission rate was 1.94 per thousand between the elevations of 6,501 and 7,000 feet. (There were but four stations in that group.)

The mortality varies greatly at different levels but is apparently not controlled by the altitude.

In order to eliminate the factor the cases were rearranged in groups for every five degrees of latitude. A study

TABLE I. Admissions to sick report and mortality from lobar pneumonia in the United States Army, 1870-1874.

Elevation	White Soldiers				Colored Soldiers			
	No. Cases	Admission rate per 1000 mean strength	Percent of Mortality	No. Stations	No. Cases	Admission rate per 1000 mean strength	Percent of Mortality	No. Stations
0 to 500	219	7.16	14.2	57	4	5.35	0	3
501 to 1000	145	10.01	11.0	29	44	18.35	18.2	7
1001 to 1500	99	13.77	6.1	10	4	7.87	50.0	2
1501 to 2000	41	5.43	17.1	13	13	4.61	53.8	3
2001 to 2500	8	7.92	12.5	1	0	0	0	0
2501 to 3000	30	6.39	23.3	8	5	63.29	40.0	1
3001 to 3500	3	8.39	33.3	2	0	0	0	0
3501 to 4000	0	0	0	1	10	38.02	30.0	1
4001 to 4500	13	5.38	15.4	6	0	0	0	0
4501 to 5000	27	7.93	14.8	8	4	26.13	25.0	2
5001 to 5500	20	8.76	5.0	4	0	0	0	0
5501 to 6000	4	2.28	25.0	4	11	25.64	18.2	2
6001 to 6500	40	10.64	10.0	6	0	0	0	0
6501 to 7000	5	1.94	60.0	4	0	0	0	0
7001 to 7500	16	6.80	25.0	4	0	0	0	0
7501 to 8000	3	3.91	0	2	0	0	0	0

of the tables thus formed showed no relation between the mortality and altitude or latitude. This will be well illustrated by a study of the data between the 30th and 35th parallels which is given in Table II. Stations with less than four cases have been excluded from the table.

In this table there are three stations in Texas, Forts Richardson, Griffin and Concho that have a considerable number of cases. They vary in latitude about two degrees and in altitude about eight

find that the station with the greatest altitude has no mortality, while Columbus, Georgia, with an altitude of 300 feet has a mortality of 40 per cent.

#### CONCLUSIONS.

From the statistics here presented we may conclude: 1. That altitude has nothing to do with the mortality from lobar pneumonia. 2. That latitude within the range afforded by the territory of the United States has nothing to do with the mortality. 3. That the mortality amongst the colored soldiers is about twice as great as amongst white soldiers.

#### REFERENCES.

(1) *Medical Record*, New York, Vol. 70, 1906, p. 656.

(2) *Circular No. 8, Surgeon General's office*, 1875, p. viii.

TABLE II.

Name of Station	Latitude	Elevation	Number of cases	Percent of Mortality
Fort Pulaski.....	32	about sea level	36	0
Charleston.....	32	52	4	25
Little Rock.....	34	150	6	0
Columbia.....	34	300	5	40
Chattanooga.....	35	783	4	0
McPherson Barracks	33	1,078	5	20
Fort Richardson...	33	1,119	29	0
Fort Griffin.....	32	1,346	28	4
Fort Concho.....	31	1,900	11	9
Camp Lowell.....	32	2,530	6	16
Fort Bliss.....	32	3,600	10	30
Whipple Barracks..	34	5,389	4	0
Fort Bayard.....	31	6,022	7	14
Fort Union.....	35	6,700	9	11
Fort Stanton.....	33	7,500	6	0

hundred feet. In these cases the mortality apparently increases with altitude and decreases with latitude. Considering the other stations of the table, we

For *sprained limb* take a long roller towel, dip it in hot water, as hot as the hands will bear, then commence with one end of the towel and bandage the sprained limb. Continue to pour hot water frequently over the bandaged limb till you have eased the pain. The after treatment may require bathing with cold water to strengthen the joint.

*Ipecac*, if given in small doses, is one of our best remedies in overcoming irritation of the mucous surfaces; and in children, where there is an irritating cough, and the child is unable to obtain rest, in small doses, say five or ten drops in half a glass of water, a teaspoonful every hour, will be found of great value.

Knitting needles find another purpose as a means of *rupturing the membrane* when this is needed, as it often is, in obstetrical work.

Hamamelis unguent frequently applied to *anal fissures and tender piles* will soon relieve.

Iodised phenol has been used with success in the treatment of ringworm of the scalp and body.



## NUTRITION IN TUBERCULOSIS.\*

By CHAS. C. BROWNING, M. D., Monrovia, Cal.

Since Brehmer, over a half century ago, expressed the conviction that phthisis was curable, and acted on that conviction to the extent of preparing a place for treatment of phthisical patients with the idea of curing them, until the present time, interest has grown in the therapy of this disease.

Physicians have gradually come to regard the consumptive as a more hopeful case instead of one who must die, and a ray of hope has been held out to such patients which has increased with time. Hope was high when it was announced that Koch had discovered tuberculin, and the disappointment was correspondingly great when the full realization of the hoped-for results were not realized by those who hastened to use the new remedy.

The agitation of the subject at that time attracted the attention of the general public, as well as the medical profession, and paved the way for the campaign which is now being encouragingly waged against tuberculosis based on Koch's discovery of the tubercle bacillus, and the subsequent study of its relation to this disease, not only as regards communicability, but also its pathology and treatment.

Within the past five years much has been written in medical literature, and much time of the medical societies devoted to the symposia on this subject, and much has been written for the popular press, and many addresses delivered before different lay audiences regarding prevention and treatment of tuberculosis.

Many of these have been thoughtfully prepared by competent physicians, while others have been prepared with less care and by persons with limited knowledge of medical subjects. The sum total of this agitation has been for good,

but some wrong ideas have, however, been inculcated.

The fear of the disease has in a measure been transferred from the person known to be suffering from a tubercular infection to a large number of people supposed to be free from it, but who live in great fear that they will become infected.

The fear of the infection is on account of real and fancied dangers. The lessening of fear of those infected as compared with the same class a few years ago, is because of the hope which is offered by treatment.

Both have been overdrawn in many instances. The intelligent, careful, properly directed patient is not dangerous to his associates, in ordinary relations of society, nor is the cure of the infected individual so easily accomplished by routine measures as some would lead us to believe. There is a hope for cure of a large percentage in the early stages and for arrestment in many of those in the more advanced stages, but to obtain the best results requires serious and careful consideration of each individual case; the general instructions to live in the open air in a favorable climate, eat a prescribed number of eggs and drink a large quantity of milk each day, in addition to ordinary nourishing food, is not sufficient to give the patients the best chance for life. Fresh air, diet and rest or regulated exercise constitute a valuable and popular trinity, but have been continuously abused by their friends, nor do they constitute all that should be done.

The essentials of treatment consists in bringing to a high standard of health the body and mind and the administrations of such remedies as have a specific action against the infection. Every means at our command should be

\*Read at the meeting of the Los Angeles County Medical Association, October 2, 1906.

brought to our aid to accomplish these results. The tendency of tuberculosis to recover without treatment is shown by the large number of persons dying from other causes in which healed tubercular lesions are found and who never knew that they had been infected. These cases are sometimes cited to show that treatment is unnecessary. It should be remembered, however, that in most of these instances the infected area was limited to a small extent. When the infection is sufficient to produce symptoms by which the disease may be recognized, however early, the patient is seriously ill, may be not apparently so, or not necessarily immediately dangerously so, but such that unless checked will surely eventually end fatally. The importance of an early diagnosis cannot be too frequently and earnestly insisted upon. With the diagnosis begins the first step in treatment—the psychical—for the manner of imparting to the patient the information that he is tubercular will often determine whether or not the patient remains for treatment with the physician or goes from his office determined to find a physician who will tell him he has no tubercular trouble; whether he is depressed from the shock and discouraged, feeling helpless and hopeless—in condition to be an easy prey for the charlatan and quack, or inspired with confidence that he may recover and that in his physician he has a true friend who is interested in his welfare and able to direct him in the battle against disease and strong enough to support him if his courage fails and he begins to weaken. A few days or weeks of treatment will avail little, it is a matter of months and years—months at least of active treatment and control and years of direction after active symptoms have ceased and the patient returned to active life. A bond of sympathy should be established between physician and patient at the beginning and must be

maintained, as well as confidence on the part of the patient.

The hopefulness of the tubercular patient is at times wonderful and lasts to the end of the disease, even in fatal cases, but others are greatly depressed throughout their illness and require constant encouragement. The hopeful case may need equally as much watching as the more depressed, especially during favorable progress. They frequently become careless, at times treating their condition in a trivial manner.

Explain fully the *nature* of his disease to the patient and point out the hopes and dangers as may be required to secure, and maintain his interest and co-operation in treatment. Tact will enable the physician to give the required information without producing shock, and the feeling on the part of the patient that he is being told the truth inspires confidence. Hopefulness increases the tone of the digestive system and favors nutrition.

One of the earliest symptoms of tuberculosis is loss of weight, and this continues until the extreme degree of emaciation, which is characteristic of the latter stage is reached, if the case makes uninterrupted progress to fatal termination. If there is a stay in the progress of the disease, it is generally marked by the checking of this loss, and in most cases of recovery, the former normal weight is regained and generally slightly exceeded. To check this destruction of tissue and make good the deficit by increasing the nutrition of the body, deservedly holds an important place in the treatment.

In the dietetic treatment of tuberculosis, many of the rules which govern the feeding of patients suffering from anorexia in acute diseases or with temperature above normal must be disregarded. Patients who have fever and a disgust for food will frequently find both symptoms much improved by forcing themselves to eat of nourishing foods and will begin to at once gain in weight,

while others who have been steadily losing weight and strength and suffering from slight afternoon rises of temperature will frequently find all symptoms improved by adding to their ordinary diet such highly nutritious food as a half pint or a pint of milk with each meal, or one or two raw eggs taken after each meal, or both the milk and eggs may be added. To this food, of course, should be added rest, fresh air and other adjuncts of treatment. Food in many instances is taken with advantage between meals.

It is necessary to consider all conditions of the patient, in prescribing a diet, not only the physical condition, but the environment under which the patient must or can live—their social condition and financial ability. A patient of limited means may be spending money for indigestible sweetmeats of comparatively low nutritive value and suffering from mal-nutrition, when if properly directed, they might for the same amount obtain that which would be ample for their needs, and the wealthy may be trying to tempt their appetites by the use of delicacies, which only tickle the palate and derange digestion. For this reason, the articles of food and the quantities which may enter into each one's diet should be carefully considered, endeavoring to find sufficiently nutritious food in such forms and varieties as will be eaten with as great relish as possible and be easily digested and assimilated.

Most recent works contain diet tables which are of value, if used as a basis of food, but each individual case must be carefully studied separately, and I know of no portion of the treatment which presents so many phases and requires more constant watching. A routine will surely be unsatisfactory.

Since forced feeding has been introduced, it has been carried to great extremes, and many have taken hold of it on the principle that if a little is good,

more is better, and pressed it to the utmost.

That such treatment is frequently followed by at least temporary results which are almost marvelous, and highly gratifying to all concerned, is true, and the amounts of food fed to a tuberculous patient confined to bed has been great.

The following extract from a contribution to the literature of tuberculosis, which occurred in the *Journal of the American Medical Association*, Jan. 20, 1906, is as follows:

"It is generally supposed that forced feeding is contra-indicated in the rest cure, that the patient will suffer from auto-intoxication, anorexia, diarrhea and loss of appetite, as he certainly would in health, but in tuberculosis the opposite is the case. When active exercise is taken the patient does suffer from auto-intoxication and fatigue toxins, which evidence themselves by febrile phenomena. At the present time I have a patient, 25 years old, with extensive disease of the right lung, who is taking 36 raw eggs and a gallon of milk, besides his three regular meals each day. He has gained 47 pounds in weight in three months. During all this time he has been kept perfectly quiet. He has suffered no inconvenience from this enormous quantity of food and he says he feels perfectly well. His fever has gone, cough and expectoration are much less, and with proper care I have no doubt that he will entirely recover." It would be interesting to know what the final outcome of this case has been.

Other similar cases have been reported, but this is sufficient for illustration. There are, I believe, few people who can take this, or any where near this amount of food continuously with benefit, and I believe there is risk of irreparable damage to the patient.

The report of such cases encourages others to attempt the same, and if a feeling of well-being is experienced,



and there is a certain amount of pride in making a record, and further encouraged by the increase in weight, it is continued until this increase may be carried far beyond normal. Increase in weight beyond what had been formerly attained may not necessarily be greater than normal, as the age of the patient may be that at which they would normally have increased in weight—as in young persons, or persons about middle life in families who habitually develop increased weight at that period. I recall several cases who have done this and the weight has remained permanent with permanent arrestment of symptoms, nor should the greatest weight of the past always be considered normal.

If the increased weight, much beyond the normal of the individual, is accomplished by excessive feeding, it may have been done at the expense of the digestive system which is over-taxed. When this occurs the digestive system after a time fails to care for the necessary amount of food to nourish the patient, and the failure is rapid.

I could cite several instances of patients who have applied for admission to our sanatorium who have taken from 12 to 18 eggs, and 2 to 3 quarts of milk per day, in addition to ordinary diet, for two or three months, and who have made rapid gain. Suddenly the appetite has failed, the digestive functions become greatly impaired and the loss of weight rapid. With this destructive metamorphosis the tubercular process became active—subacute in character—and the course of disease rapid, and has generally terminated fatally.

The following explanation of these conditions have been offered by Robin and Binet in the *Lancet*, Oct. 14, 1905, abstracted in *Progressive Medicine*:—

"The regulation of diet should more largely be guided by a study of its effects upon the respiratory exchanges. They report their observations on the relative and dietetic value of raw meat,

eggs, and gelatine. As regards raw meat they find that 150 grams (3.5 ounces) per diem is the maximum that can be given without over-stimulating the tissue exchanges, which in phthisis are already too active. In the same way they conclude that six eggs are better than twelve, for with the larger allowance the respiratory exchange increases by 13.75 per cent., the formation of carbonic acid by 20.84 per cent., and the total consumption of oxygen by 8.78 per cent. Whereas if the number of eggs is reduced to six the respiratory exchanges fall by 20.35 per cent., the carbonic acid by 13.26 per cent., and the total amount of oxygen consumed by 25.34 per cent., whilst the increase in body weight is not diminished. Twenty grams of gelatin added to the hospital diet produce a rapid fall in the respiratory exchanges (from 10 to 18 per cent. of the total amount) in cases where it is well borne. This economizing action remains unimpaired if the daily rations of raw meat does not exceed 100 to 150 grams (3 to 3.5 ounces).

An article in the *Transactions of the British Congress for the Prevention of Consumption*, 1901, by Dr. Bardswell, epitomises the results of a series of observations as follows:

"To epitomise the results very briefly, we found that:

(1) Patients when not closely supervised did not eat a sufficient amount of food, although plenty was given them, so that patients on the hospital routine improved quicker when placed under close observation.

(2) The patients in the special sanatorium wards did excellently in every respect, judged both from a clinical and experimental standpoint. The diet of these wards is of practical interest, namely, three meals daily, made up of: meat, 7 oz.; bacon, 2 oz.; egg, 1; milk, 3 pts.; butter, 3 oz.; bread, 7 oz.; sugar, 1 oz.; pudding, 5 oz.; vegetables, 6 oz.

(3) Patients originally on this diet, when given considerably larger quanti-

ties of food, such as 6 or 7 pints of milk, 12 or more ounces of meat, and in several cases with the addition of an ounce or two of somatose or lactose, did not give such satisfactory results. Weight was certainly gained more rapidly, but in several cases this gain was associated with deterioration of general health, and laboratory results indicating deranged metabolism. With regard to pushing proteid, we found that after a certain point much of the increased intake was wasted, in several instances as much as 50 per cent. of an increase being immediately excreted. Associated with this waste we found also a marked rise in the ratio of aromatic sulphates excreted, indicating increased intestinal putrefaction, and a steady fall in the per cent. absorption of nitrogen.

"Coincidentally with these experimental figures, indicating deranged metabolism, the patients' conditions, from a clinical standpoint, became less satisfactory. Loss of appetite and dyspeptic symptoms developed, and in one case vomiting occurred, symptoms all previously absent."

In our recent report we reported 94 cases, showing that during treatment "only one first stage patient lost weight and that was due to vomiting of pregnancy. In this case a good test of the results was given by the completion of pregnancy and birth of a healthy child with no ill effect upon the mother. Two second-stage patients showed a loss of weight; one treated in the office, the other in the sanatorium. This was a matter of 2¾ pounds in one case and 3 in the other. Of the third-stage patients treated in the office, two lost weight; of those in the sanatorium, ten. Thus there was a loss of weight in fifteen patients out of ninety-four, an average loss of 9¼ pounds.

In this same report by comparing the number of pounds lost or gained with what was given as the normal weight

of the patient, before the beginning of the illness, we have the following:

Of those treated at the office who were discharged as apparently cured, we find 4 have failed to regain what was given as their normal weight by an average of 6 pounds. 12 had exceeded their stated normal weight by an average of 6 pounds. One regained just normal weight, as given. Of those discharged as arrested, 7 had failed to reach their given normal weight by an average of 9 pounds; while 7 had exceeded what was given as their normal weight by an average of 8 pounds. Of 2 who were discharged as improved, one had failed by 2 pounds, the other by 6½ pounds, making an average of 4¼ pounds less than their given normal weight. Of 2 who were discharged as unimproved, there was an average of 30½ pounds below the stated normal weight. Of cases treated at the sanatorium, who for the same classifications, were farther advanced than the corresponding classes treated at the office, we find the following:

Of those discharged apparently cured, 4 had failed to reach their stated normal weight by an average of 3.4 pounds, while ten had exceeded their given normal weight by an average of 10¾ pounds. The greatest gain above stated normal weight was in a patient who exceeded what was given as normal weight by 34½ pounds. She had arrived at that age at which it was a family trait to take on flesh, and she continued to gain for several months after leaving the sanatorium.

One patient, apparently cured, weighed exactly what was given as the normal weight.

Of those who were discharged as arrested, 11 failed to attain their stated normal weight by 8.2 pounds; while 13 exceeded their given normal weight by 7.1 pounds. Of those discharged improved, 2 had exceeded what was given as their normal weight by an average

of 1¾ pounds, while 11 had failed to attain their given normal weight by 22.3 pounds. Five were discharged as unimproved, the average weight being 14 pounds below the stated normal weight. Two died, and averaged 18½ pounds below what was given as normal.

From these figures it would appear that those patients who were discharged as apparently cured, with the exception of the 2 noted above, not only increased in weight over what it was when they came to the sanatorium, but all, excepting 6 others who very nearly regained their given normal weight, exceeded this. This, however, with the exception of the case stated above, who gained 34½ pounds, and 3 other cases who gained from 10 to 14 pounds each, for the same reason, that of age, the average for the remainder was 5 pounds above the stated normal, notwithstanding the general average of this class was 10.75.

The above table shows that most of those patients who were apparently cured, in all stages of the disease, whether treated in the office or sanatorium, raised their weight near to or slightly above normal; those in whom the disease was arrested, most of them were not quite able to regain what they had lost; those who were improved fell still farther short, while the unimproved showed a loss of several pounds. From this we might draw one or two conclusions; either that the result obtained depends upon the patient's power of digestion and assimilation, which is generally believed; or, that accordingly as these patients improve, so does their power of digestion and assimilation improve.

We may also fairly conclude that in the early cases it is desirable to raise the weight to or slightly above the normal, but that it is not necessary that this should be greatly exceeded. In nearly all instances these cases have remained in as good a condition of health as when they left the sanatorium,

and some have slightly increased their weight. The time since they were discharged varied from 10 months to 3½ years—April 1, 1903 to January 1, 1905.

In conclusion I believe that it is desirable to bring the body to as high a state of nutrition *as it can be maintained*, but that to bring it to a state much beyond which we may reasonably hope to maintain, is a mistake. Retrograde changes, from whatever cause, are undesirable in the tubercular case, especially is this true if the digestive functions are impaired. To this end the diet must be carefully considered.

The object of treatment is to restore the patient to a life of usefulness under normal conditions. As progress toward recovery is made, extra diet which has been supplied to combat the diseased condition should be gradually and carefully withdrawn.

To these measures should be added others of no less importance—fresh air, careful regulation of exercise, rest, the careful and intelligent use of culture products, and treatment of special symptoms.

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#### DISCUSSING OF DR. BROWNING'S PAPER.

DR. TH. DAVIS—Was heartily in accord with the points brought out by Dr. Browning. To his own mind, to exceed normal weight was to invite degenerative changes. Would emphasize what had been said about rest. Too often, patients on their own volition or on the advice of friends walk themselves to death. The hopeful temperament of consumptives was remarkable. Thought forced feeding was much overdone. The patient should receive only so much food as he could make use of and not what he could digest.

Dr. Browning had mentioned gelatin, which with milk, prevents curdling. One half ounce of sugar four times a day was of value, in hot water or milk.

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DR. HENRY HERBERT—Dr. Browning had considered in brief space a very important subject. The anorexia of tuberculosis, which was very difficult to treat, was of obscure pathology: might be due to toxemia or again to an atrophy of the secretory glands of the stomach. A routine over-feeding is not desirable. Individualization necessary. If patients have fever, diminish the food but let it be very nutritious.



DR. F. M. POTTENGER—Specific instructions are necessary as to rest, diet and so on. We are believing less in over-feeding than formerly. Cited several case histories in which patients had gained much weight only to lose it in a few days. In trying to build patients up, the normal weight of patient, not the patient's previous highest weight, is what is sought. Too much stress has at times been laid on nutrition, to the detriment of attention to other functions. The aim is to increase the resisting power of patient. Good rule would be to eat as little as possible, just so there is a proper gain of weight, which in itself does not mean that tuberculosis is cured. More than a gain of weight is necessary if immunity is to be established. As to Dr. Herbert's statement to feed the fever patient who has phthisis along the same lines as fever patients with other diseases are fed would disagree somewhat. Tuberculosis is a chronic febrile disease and on that account one should feed these patients more.

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DR. GEORGE H. KRESS—The nutrition in patients with tuberculosis was a most interesting and important topic. The purpose of the food was to build up the vitality of the patient, was to increase the physiological resistance of the tissue cells and cells. In seeking to develop this increase, the increase of weight was an incident, was to be taken merely as an indication as to the extent to which the efforts to increase strength and physiological resistance were successful.

As had been stated, the successful treatment of tuberculosis rested upon individualization in treatment, depended in fact upon attention to details. To treat the disease successfully one did not treat "merely" but the "concomitant," if necessary, therefore, for the physician to acquire over his patient a direct control concerning diet, it had been shown him as the lines concerning the diet does not had been closely and minutely applied. Many patients had been harmed by imagining that the cut of their life would "thoroughly" do the contrary, in most cases, it would not a life of exercise but a life of rest, not of harm.

Abundance of nutritious food also has been misinterpreted to mean an excess of over-feeding. As long as increase of weight meant increase of strength, we gave maximum amounts of nutritious food, if the patient had a digestive system that could assimilate it. A good ordinary rule was three regular mixed meals a day to maintain the strength and weight and two to four between-feedings in the twenty-four hours, of milk, eggs or broths, to lay on extra weight and strength. Eating slowly was important, keeping mouth sweet and clean likewise. In most patients a fifteen minute rest prior to main meals was advantageous. So also a half hour or hour rest in reclining position immediately after meals. This gave patient best opportunity to digest and assimilate food. An appetizing service was of great importance in tempting the capacious appetite of the consumptive.

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DR. E. C. E. MATTISON—Referred to experiments of Dr. Luman Halkley of New York on puppies in which he had shown that milk on an empty stomach would be absorbed without stimulation of gastric glands. Gave the milk without cracker. He had himself gotten good results with this clinically.

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DR. C. C. BROWNING—Spoke of the necessity of taking patient's temperature into consideration. Do not count yourself too much as to prognosis. Some patients are febrile, others depressed and there must be taught surrogates. Forced feeding had no doubt been over done and given several cases with rapid gain in weight from over feeding in which loss of weight from a gastro-intestinal disturbance was over more rapid.

As to rest before and after meals, rest before meals was advantageous but some patients did not do well if they rested too long after eating. As to alcohol, in form of light wines at times might be of value but it was a dangerous remedy, especially with women patients. Over exercise and overwork it was also dangerous.

## STRABISMUS IN CHILDREN.\*

BY BENJ. F. CREECH, M. D. LOS ANGELES, CAL.

This paper is, for the most part, a protest against the unscientific and pernicious advice so often given to parents of strabismic children.

For the sake of brevity, and, to more clearly elucidate the principles desired to be brought out, only concomitant

spasm of the internal variety, or strabismus convergens, will be considered.

Upon considering the conditions governing this muscular incoordination in children, and the permanent and baneful effects to vision which inevitably follow its non-correction in its incipency, one

\*Read before the California Medical Society, April 8, 1906.

is amazed at the widespread fallacy which exists among the laity, and the apathy of some of the profession regarding the proper care of these little patients.

For some unknown reason mothers are quick to accept the popular erroneous advice:

1. That the child might "out grow" the defect.

2. That nothing is to be done until the child is past six years of age.

3. Treatment after the age of six or eight is surgical.

The first statement is false, except in very rare instances. The second is wholly false, and the third only true by reason of palpable neglect to properly care for the case, at an earlier period, when treatment, other than surgical, might have been successful.

The usual definitions of strabismus, given by text-books, do not define the whole condition. They simply convey one of the symptoms. Their definitions run as follows: "A faulty co-ordination of the eyes." "A deviation of the visual axis of one of the eyes from the correct position of fixation."

Two primary and essential conditions are always present in concomitant, convergent squint.

1. "An abnormal convergence of the visual axis."

2. "A defect in the brain of the fusion faculty."

Other conditions may be present such as:

1. Congenital Ambliopia (a dimness of vision without macroscopical changes in the eye) which is very rare.

2. Acquired Ambliopia, which always occurs in the monolateral form of squint.

3. Suppressed vision of the deviating eye.

4. Hypermetropia, a very frequent associate.

During the first few months of the infant the movements of its eyes are

uncertain and can, for a moment only, fix an object binocularly.

It learns to do so by slow degrees, as that faculty is developed in the brain. This power before becoming well established is subject to temporary disturbance by slight gastric or other disorders.

One of the eyes will deviate in its horizontal plane but never in the vertical. At the end of the first year the eyes will make a considerable effort in the interest of binocular vision as demonstrated by the power to overcome prisms. The fusion center normally reaches its full development before the end of the sixth year.

The conjugation of the two eyes for vertical movements is well developed from the earliest infancy, and one eye does not turn up or down without the other. Differing from the general opinion, it will be found that both the internal and external recti muscles of the squinting eye retain their full relative strength. The external muscle is no weaker, or the internal no stronger than in normal eyes.

Exceptions are occasionally found in long-standing cases, but never in the recent ones.

The squinting eye can make excursions in all directions the same as the straight, or fixing eye. There is no motor defect, the eye simply assumes a wrong starting point on account of faulty brain impulses. At the first appearance of a deviation, the squinting eye always has the power of central fixation when the straight or fixing eye is covered, and the vision is nearly always as good in one eye as in the other.

Congenital Ambliopia of the squinting eye is far less frequent than is generally supposed, in fact, it is rarely found. It is never responsible for the extreme blindness so often observed in old neglected cases. This blindness is

almost universally a result and a cause of the strabismus.

The visual acuity of the deviating eye may be perfect, but the picture formed in this eye is mentally ignored, or suppressed, the attention being directed solely to the impression in the fixing eye. This suppression of the image is not a voluntary act. The inability to receive impressions from both eyes, simultaneously, is due to defect in the fusion center in the brain, which is also the essential first cause of the deviation.

In an untreated case, the vision of the deviating eye, being entirely suppressed, gradually deteriorates from disuse, until, in the greater number of cases, central fixation is lost and the vision reduced to counting fingers close to the face. The younger the child the more readily does this ambliopia from disuse occur. It is a common knowledge that all cross-eyed persons are blind in the deviating eye. This is true after the deformity has existed for some time, but does not hold good at its beginning.

This vision was lost by neglect to direct the brain impulses to their proper channels during early life.

The first definite theory of the cause of convergent squint attributed the affection to a shortening of the internal recti muscles. Following this theory naturally came indiscriminate muscle cutting. During the height of the disaster, a large number of internal squints having been converted into irreparable external deformities, Donders came to the rescue of the remaining sufferers by publishing his classical work on the close association of accommodation and convergence.

*Donders' Theory*.—The visual axes of normal eyes when looking at a distance are parallel. Distant images are focused upon their retinæ without effort or labor.

To look at an object one foot away he must turn the eyes slightly inwards (convergence,) in order that both visual axes may meet at the object. At the same time each eye must be focused for near vision (accommodation) in order that the object may be seen distinctly. These two acts, accommodation and convergence, being always performed together, have become associated by hereditary habit, so that it is difficult to converge without accommodating or to accommodate without converging. Hypermetropic eyes on the other hand, to see clearly, must focus for distant objects and still more so for those that are near. He must accommodate in distant vision to a degree corresponding to his hypermetropia. In near vision he must accommodate both for the hypermetropia and the nearness of the object.

This extra effort at accommodation causes a greater tendency to converge. Donders considered this tendency to be the cause of convergent squint, and advised optical correction of the hypermetropia to correct the squint.

The demonstration by Donders of these physiological facts was a long step in the direction of the rational treatment of convergent strabismus. His assumption, however, that hypermetropia was a fundamental cause of this deformity is erroneous.

It is true that nearly all squinters are hypermetropic. The reverse of this statement does not by any means hold true. If so we would have a world of cross-eyed children and straight eyes would be the exception, as the vast majority of children are born hypermetropic. The extra effort to accommodate, necessary in the hypermetrope, with its associate convergence, is only one factor.

The treatment of strabismus in children should be instituted at the earliest possible time.



Ever bear in mind that the vision of the deviating eye will be irretrievably lost in a short time unless the visual axes can be restored to their relative normal directions. That the eye, as a rule, is not blind at the beginning of the affection but becomes so from non-use and lack of proper brain stimulus.

There are five therapeutic measures at our command:

1. "*Correction of any refractive error which may exist.*" After the child learns that it can see better with the glasses than without them, no trouble is experienced in keeping glasses on even infants.

2. "*Occlusion of the fixing eye.*" This is done by placing a pad of gauze over the eye and stropping with a bandage or adhesive plaster.

3. "*Instillation of Atropine.*" The good or fixing eye only, should be atropised. By paralyzing the accommodation it is unable to see close objects clearly, therefore, employs the deviating eye for this purpose.

4. "*Training the fusion sense.*" Worth's Amblyoscope is the most ingenious and best method for accomplishing this exercise. This is a valuable acquisition to our armamentarium for training the fusion sense. "This cannot easily be employed upon children under three years of age, as

their concentrated attention cannot be secured."

5. "*Surgical.*" Surgical means should be employed in those cases in which the fusion faculty has been developed by use of the Amblyoscope but show no tendency to a decrease of the angle of the deviation. There is no objection to performing the operation early after other means have failed to induce parallelism. The do-nothing plan, unfortunately so often advised and followed, until the child is eight or ten years of age, places it beyond the pale of surgery or any other means to restore its lost vision. An operation at that time is only useful for its cosmetic effects.

In closing a word in behalf of these little sufferers.

Suppose a person to be suffering from an insidious disease of the eye, the character of which would certainly destroy useful vision in a few months if left to Nature, but that if properly treated he stood a chance of at least ten to one in favor of retaining his sight? What advice would his physician give him? Certainly not that so frequently given mothers of Strabismic children.

In the case of helpless children our culpability is increased tenfold. They are doomed to blindness without their knowledge or consent.

NOTE.—Quotations from "Squint" by CLARA Worth.

## THE HOUSING CONDITIONS OF LOS ANGELES.\*

BY TITIAN COFFEY, M.D., LOS ANGELES.

It affords me great pleasure to have this opportunity of presenting for your consideration a few facts in regard to the slums and housing conditions in certain sections of our city. It is a topic of vital interest to all public minded citizens and one upon which time and money may be spent with profit. It is one in which men and

women are equally concerned for it touches deeply the home life of every dweller in the so called slums; it involves the questions of disease, of morality, of drunkenness, of crime, of marriage and of death; in fact all the issues of sociology. And quite as important from the civil standpoint, it stands for or against the development

\*Read before the Friday Morning Club of Los Angeles, November 19, 1906.

of good citizens from the children born and reared under such environments.

To one who comes in almost daily contact with it, in whatsoever capacity—settlement worker, visiting nurse, physician, city health inspector or casual visitor, it appeals very strongly and I trust the few thoughts I may be able to give you this morning may be of such interest as to arouse your intelligent support in the work and efforts of the Los Angeles Housing Commission.

These remarks this morning are not in the nature of a report, but simply an attempt to familiarize you with existing conditions and show you what the Housing Commission is trying to do. The work is so far reaching and involving as it does not only the immediate but future welfare of the city, anything like a report is at present out of the question.

Work along the lines of improvement in slum conditions has been done in various cities in a more or less active way for the past fifty years.

Much time and money have been spent without really accomplishing anything and it was only in 1902 and 1903 that things actually got down to a working basis, by the establishment of the Tenement House Department of New York City, by Hon. Seth Low, then mayor, with Robert W. De Forest as Tenement House Commissioner.

Mr. De Forest and his associate, Lawrence Veiller have accomplished a magnificent work. In the face of great opposition the New York State Legislature in 1901 passed the bill now regulating the construction and inspection of Tenement Houses in Greater New York. The Octavia Hill Association of Philadelphia was established in 1896 as a stock company "organized to improve living conditions" and has accomplished much good.

Even Boston, the city of culture and refinement, has had its trials and tribulations. Robert Treat Paine in an address at the sixth annual meeting of the American Academy of Political and Social Science in 1902 stated, "A crusade for the extirpation of the Slums of Boston has been waged for the past fifteen years, thus far with no great success—In 1895 a special committee of the Common Council was appointed to consider what improvements could be made in the Tenement District of Boston—In 1897 a study was made under the direction of the Twentieth Century Club. A Tenement House Commission will probably be appointed by the mayor this year to consider and report upon existing conditions and possibilities of improvement." This Commission was appointed two years later, 1904.

The New Jersey Tenement House Commission was appointed by Governor Franklin Murphy in 1903 and made its first official report of existing conditions in the principal New Jersey cities the following year.

Miss Jane Adams in 1900 said, "Until a year and a half ago we thought that all our problems in connection with the housing question were in the future."

The Housing Problem Commission of the Cleveland Chamber of Commerce made its first report in 1904. They believed at first they had no housing problem and were much surprised when they came to investigate, to find the serious condition their city was in. They strongly urged upon other cities the necessity of taking up this work before it had secured too strong a hold. Indeed Robert De Forest lays down the axiom, "Let none suppose that our cities, however small, will remain free from the evil of the tenement house, which in larger cities has necessarily evolved in self-protection, tenement house regulation. The small cities need

not go through the bitter experience which is teaching New York and other cities their lesson. *They can, by timely regulation prevent the crystallization of unsanitary conditions into brick and mortar.*"

We thus see what an awakening has taken place throughout the country and it behooves Los Angeles to deal with this question while in its incipency and profit by the guidance and experience of others, rather than let it grow upon us and then have a formidable problem that will take a vast sum of money and time to correct. As it is, the problem is of sufficient magnitude to already be a menace and we must do our best to correct it!

The present Commission recently appointed by the mayor, Hon. Owen McAleer at the request of the Municipal League was simply appalled, when it began going over the reports and literature of other cities and got into communication with the various Eastern Housing Commissions, at the magnitude of the work and the length of time frequently involved before any results could be obtained. In a personal letter from Mr. Veiller to the Committee he says, "First sit down and study your existing conditions, even if this is the only thing you accomplish in two years."

The development of the tenement house is practically the same in every city. Los Angeles, thirty years ago had no such condition. It begins when old homestead property is given up and the people of position and means seek other residence sites, their former homes becoming untenable by the encroachment of factories or business blocks, as invariably occurs in rapidly growing cities.

It begins with the coming of the so called "down town district." These old homes, before being demolished, become cheap boarding houses and from this rapidly pass into the apartment or

tenement house, by the subletting of one or more rooms, to a family for house-keeping purposes. The same is true in the outlying portions of the city. Here are cottages owned or rented by people of little or moderate means. The property deteriorates in value or from increased cost of living the house holder inaugurates the pernicious system of subletting, and within a few months the neighborhood becomes one of tenement houses—houses in which two or three families are living in an over-crowded and unsanitary condition! To put it shortly *the tenement house is developed when houses or cottages are sublet.*

The object of a Housing Commission may be summed up by the statement that it is for the purpose of investigating and remedying existing evils and the *prevention* of like conditions in the future. The minutia consist of thorough inspection as regards improper construction of buildings used for human habitation, overcrowding of bedrooms, inspection of foul cellars, defective and unsanitary plumbing, houses unfit for human habitation, deficient toilet facilities, surface drainage, and in fact all questions of sanitation. Its ultimate aims are proper legislation by means of city ordinances for the correction of these evils and their avoidance in the future, by a system of paid inspectors who will report conditions; and also the necessary civil penalties when not abolished.

The large eastern cities, especially New York, have to deal with what is called the Tenement House Question. Philadelphia and Boston, types of "Cities of Homes," and the smaller cities have what is called the Housing Problem.

The New York Statutes define a tenement as follows:

"A tenement house is any house or building, or portion thereof, which is rented, leased, let or hired out, to be



occupied, or is occupied, as the home or residence of three families or more, living independently of each other, and doing their cooking upon the premises, or by more than two families upon any floor, so living and cooking, but having a common right in the halls, stairways, yards, water closets, or some of them."

According to the definition only a small proportion of our local dwellers could be classed as living in tenement houses. Los Angeles has therefore no actual Tenement House problem, but on the other hand has a very real housing problem and one so peculiar that there is probably nothing analogous to it in any other city of the United States. We also have a serious menace to the public health in the number of improperly kept lodging houses that are multiplying with the growth of our city. This fact was especially called attention to by Dr. Knopf in his recent visit to our city. He considered the Oriental quarter a very serious menace to public health. These houses, in the poorer sections of the city, consist of sleeping accommodations arranged as bunks or tiers as in a Chinese opium joint and are indescribably filthy. Others maintain beds or cots in a long sleeping room, the bedding of which is *not* changed with the advent of a new guest, but he is allowed to occupy the bed and accumulate a varied assortment of vermin and disease germs left by the last occupant, and may deposit whatever he chooses from his own personal collection for the benefit of the next lodger: all for from ten to twenty-five cents per night.

To the student of entomology some of this bedding would prove a veritable treasure house, but to the unhappy occupant and to us as social workers it is a thing to be shuddered at and abolished.

Come with me for a moment down onto Los Angeles street, just above 2nd,

Behold a long room lined on either side with cots. A man comes in to-night afflicted with smallpox. He is assigned a bed. He removes his hat and retires clad as he left the street, shoes and all. In the morning he disappears but returns to-morrow night and is assigned to that last bed, way down on the right hand side. Again with the break of day, he leaves, only to return and be assigned that middle bed on the other side. His condition is not evident; he escapes the health inspector; or the proprietor through negligence fails to report his condition, if recognized. *The bedding is changed once a week.* Fortunate to be changed that often! What has happened? The infection of three beds! A veritable death trap to the lodgers who follow him.

Take a look at the bedding! Did you see that quilt move? Don't be alarmed, it can't get away. Figuratively speaking, it is weighted and chained by its own filth. Its positively alive! Were it loose it might walk out to the street to air itself. Epidemics are started just this way. It is only through the eternal vigilance of our health officers that we do not have more smallpox in the city.

Again we have many invalids afflicted with all sorts of skin and blood diseases, and especially tuberculosis. These people drift to Southern California on account of the climate and usually are supplied with little or no means. They naturally resort to the city and on account of poverty are forced to seek these wretched accommodations. They have come with the fond delusion that our warm balmy air will restore them to perfect health in a few weeks, and allow them to resume their occupations. *Right here* is the injustice done these unfortunates by sending them from their eastern homes, in the last stages of tuberculosis, supplied with insufficient means. Were

they let alone, under certain conditions they might regain a partial or full restoration to health. At all events, it were better to spend the last few weeks among friends, rather than dying among strangers and being buried in the potter's field.

Let me show you another picture. A physician or visiting nurse is called some night to a patient having a hemorrhage. Step into the room with me a moment. Did you notice that nasty, close smell in the hall-way as we came up? Its rather worse here, isn't it? Let us open the window and let in some fresh air. The room is small, walls dirty and cobwebby, floor covered with a filthy carpet, a smoky lamp on the dresser, or possibly a feeble gas jet burning up the little remaining oxygen in the air. A glance at the bed, shows its coverings to be nothing to boast of. The frightened sufferer lies propped up on pillows and turns appealing eyes upon us. He is a stranger in a strange land, arrived but yesterday. He has been awakened at night by a mouthful of blood and in his fright, has splashed it all over himself and his bedding. At his side, on the floor, lie several open news-papers and he has expectorated all over them. He has not always hit the mark and some of his infected sputum has soaked into the bedding and into the carpet. He is sent to the County Hospital, or dies in a few days and this death trap is again set for the next victim. There is *no change of bedding; no taking up of carpet; no washing of walls; no disinfection of this room!*

The next occupant is a frail woman, subject to "colds." She has a slight bronchial affection, but has not yet developed tuberculosis, though the fertile field is ready for the seed. She sleeps in the same bed, on the same mattress, the same pillows; she walks over the same carpet, raising microscopic particles of dried sputum laden with liv-

ing germs, with every movement. She inhales this horrible air and presently develops tuberculosis.

Do you realize what a death trap such a room is? Do you know that bubbles of sputum ejected from the lungs with a single cough will infect a sterile screen placed fifteen feet in front of you? Do you realize the common house fly is the carrier of the contagion—delights in sputum, and will infect the next piece of fruit, bread, or mouthful of milk that unhappy woman may carry to her lips?

I tell you I have actually seen such things, not once, but many times. Is it any wonder, that one of our crying needs at the present moment is the proper legislation bearing upon the inspection and disinfection of these rooms and the report to the health officer of every case of tuberculosis coming into our city?

It is unnecessary to prolong these pictures; any one possessed of judgment and a little imagination can easily realize what a menace to public health the maintenance of such places are, and can easily imagine the filthy conditions existing if they are not conscientiously cared for by the proprietors, under the guidance and direction of the health inspectors.

*The proper handling of the tuberculous patient is a matter of education on the part of the laity.*

The curious condition mentioned above and which as far as I know, there is nothing like in any other city, is the growth and development in recent years of the Cholo Court. This is a segregation of the Mexican population in various parts of the city and conditions should be seen to be realized. I have here some maps or plats of a number of these locations done by two inspectors, courteously furnished by the Municipal League, for the use of the Housing Commission. The existence

of these places has been called attention to, from time to time by the reports of the City Health Officer and the Annual College Settlement House Reports. These places consist of a lot or area of ground, upon which are built apparently, an innumerable number of small shacks, without any attention being paid to systematic or orderly arrangement. The most typical is that on Utah St., lying between Kearney and Aliso Streets, and called by the Mexicans "La Ylacha" or "The Rag." Another is on Aliso street, just east of the Salt Lake tracks and protected from public gaze by a flaming bill board. Other courts, as those upon Buena Vista and Castellar streets, lying between Bellevue ave., and Alpine street, are built around and the inhabitants make use of, the decrepit and ancient adobe houses to be found on those streets.

The development of these courts is exactly the same as that stated for the development of the tenement house. This adobe before us was the charming home of a cultured family some few years ago. Death of the head of the house and the rapid increase in our laboring classes have converted these relics of the old days into veritable pest houses. To the tourist and those unacquainted with the real existing conditions, their crumbling walls and eyeless windows are objects of romance; to the artistic soul they are objects of delight. But step for a moment behind that picturesque door. The low, cool room we expected to find, inhabited by the laughing senorita and the sound of the soft guitar, vanishes in a flash, as our amazed eyes behold the filthy walls and floors and our astonished nostrils catch the combination of odors that assail us as we cross the threshold. Poverty stricken women, slovenly men and innumerable children answer our "Buenos dias." It is echoed by a

raft of dogs in the Patio. This latter, the delight of novelist, usually pictured as full of sunshine, sweet and clean, ablaze with flowers is a revolting sight. Clothes lines, more or less full, obstruct our gaze. Filthy garbage, leaking water faucets, dirty paths, impossible toilets, and the hum of human activity as the overcrowded inhabitants call back and forth to one another, is the picture it presents to-day. Go down tomorrow to any of those places and see if I have overdrawn it! Filth, squalor and wretchedness on every hand. Here the children play and are reared to become our future voters. Here the women cook on primitive ovens built of bricks or a little pile of stones covered with a sheet iron lid, such a one as we, when children, constructed and played at Indians on the western plain.

Lopez Court on Buena Vista just above Bellevue consists of a series of buildings divided into usually three rooms, and occupied by whites, negroes and Mexicans. These are built of wood and the pitiable part of it all is, they are of *recent* construction, but from a building standpoint are somewhat superior to the shacks to be found on Utah street. The existence of the adobe could not be prevented, but such a series of buildings *ought to have been!* Here we have 58 houses occupying one-third of a block. Each house of three rooms rents for \$8.00 per month. Those of two rooms for \$6.00 per month. The number in a family occupying such a house may be anywhere from five to eleven. The janitor laughingly said to a recent inspector, "When fifteen get into a house I begin to feel a bit uneasy and make enquiries." Cases of tuberculosis, diphtheria and other contagious diseases slip in and out, before any action can be taken by the authorities, as the tenants often move at night.

Let me give you a few facts in regard to Utah street district. A glance



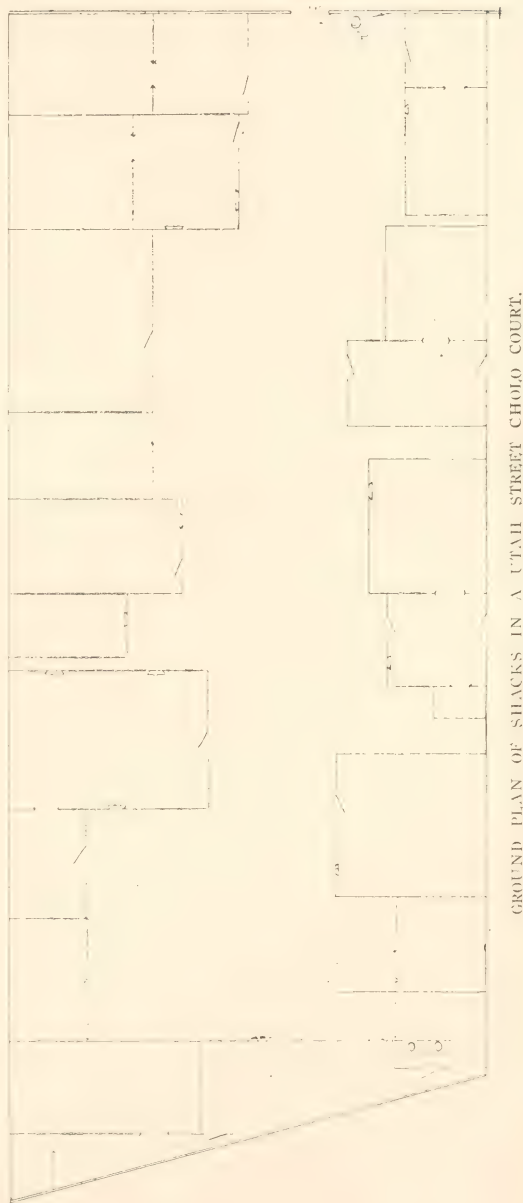
at the carefully prepared map will show you its congested condition. I quote from the report of our inspector:

"The settlement consists of ten 40-foot lots on Utah street. These lots have a depth of from 131 to 200 feet. *Rentals:* Ground or House Rent. Ground rent averages about \$1.50 per month and consists of sufficient ground for a 2-roomed house and a small yard. As the demand for space increases leases are granted to new tenants for the ground which was formerly used for yards. House rent for houses that have reverted to the agent from the tenants by whom they were constructed averages about \$2.50 *per room* per month.

*Toilet facilities:* 7 public toilets; (open courts) and 8 private toilets. These toilets have no ventilation or light; they have no partition and are used by both sexes. Most of the private toilets are constructed by an arrangement of scrap lumber, sacks, etc., and are usually without a door.

The public toilets, with two exceptions, are in a filthy condition. Thousands of flies are attracted to these places. These toilets are within 10 to 15 feet from the surrounding shacks where food is prepared and they are in the midst of such space as is available for children to play.

*Faucets:* 8 exterior, no interior. The ground surrounding these faucets is always wet and usually is the center of a muddy stagnant pool. In one case the waste water from a faucet has created a stagnant gutter about 20 feet long in which little children are often seen at play. There is no



drainage system for this waste water nor is there any for storm water.

*Yards and Paths:* Filthy condition. Garbage or rubbish can be seen lying around on every hand. The practice of throwing dirty washing water, etc.,

in the yards and paths is in vogue. The settlement is situated on low flat ground and in the bed of what was formerly an arroyo. Utah street is not graded; has no curbs or sidewalks, and consequently, in wet weather these unfortunate people are at the mercy of the water draining from the surrounding high ground.

*Regulations:* Each tenement is supposed to use an individual garbage can and carry it to the street to be removed by the city garbage wagon. The practice of using deep holes for garbage repositories is to be found in several places.

*Sewer:* No sewer on Utah street, and while there is a sewer on Anderson street, the probabilities are the settlement is too low to avail itself thereof.

*Buildings:* Are 1-story. There are a few well constructed shacks but the majority are made from old lumber and scraps of any material such as tin, matting, roofing, etc., which necessarily means they are neither water or storm proof. *Frequently the earth is the floor.* The rooms average less than 8 feet, and in some cases they are as low as 5 feet in height.

*Chimneys:* There are 2 clay chimneys. The other tenements provided themselves with stove pipes.

*Occupants:* Mexicans, with the exception of 3 Greeks who conduct the grocery store. 68 Tenements, 2 clay chimneys, 106 men, 79 women, 3 boys and 7 girls (unmarried between the ages of 15 and 21), 117 children (under 15 years). Total 312. *Seven public toilets and eight water faucets.*

*Health:* The children are dirty and ragged, with a few exceptions. There is a great deal of skin and scalp disease and sore eyes and ears among the children.

*Remarks:* There are a great many pets in the settlement such as dogs, cats, rabbits, chickens and pigeons

The inhabitants and buildings are constantly undergoing a change. The men and some of the women are employed in factories, but principally by the railways and cement contractors and manufacturers. They bear these miserable conditions bravely. They are devout Catholics. Nearly every family has a miniature altar, after the manner of the Chinese, but centralized on the pictures of Christ and Mary. The habit of smoking cigarettes is indulged in by nearly every one from fifteen years up, men, women and children, and considerable liquor is consumed. Birthday and dancing parties are held occasionally, and usually last twelve or fifteen consecutive hours." *Ten city life,* the whole area could be set in one-half of Central Park with room to spare!

Here we have the typical "Dry goods box" residence. A tenant rents his little section of ground for \$1.50 to \$2.00 per month, goes to the Boston store or Comiters, buys a few dry goods boxes and constructs his home, frequently using the ground as flooring. Being temporarily short of funds or unable to buy boxes he uses scrap sheet iron, old lagging or tinting. A door is of course necessary, but windows are not! As these mansions multiply they must of necessity become more and more crowded. "La Ylacha" with its promiscuously placed and overcrowded shacks, and blind passages around jutting corners, presents a veritable labyrinth to the stranger. Personally I have felt my way about these paths in the darkness of night, over nearly the whole area, before finding my students, on some difficult case, at imminent danger of breaking my neck or sinking ankle deep in one of the innumerable malodorous streams that abound.

Can you imagine anything more wretched than such conditions? Can you realize what such environments mean to the children being raised there? Can we have any idea of the notions of

morality or sanitation, or of their duties to their neighbors that these children must imbibe under such surroundings? It is hard to believe that in our beautiful city with its handsome homes and lovely parks, such places are allowed to exist and multiply! In a way these people seem happy and make an attempt at cleanliness, but this is usually confined to the interior of their homes and not to their surroundings. A glance into some of the rooms will show clean floors, clean beds, bright pictures on the walls and every where evidences of their religious belief. I firmly believe many would better their surroundings if they could, but it is largely forced upon them.

The women of these courts are of a very domestic nature. They seem to love their homes and make some sort of an attempt to care for their children. Not so much can be said for the men. The marriage relations are by no means on a high moral standing.

It is the duty of any landlord or agent of any tract to keep it in good sanitary condition. The tenants will not of themselves do it, for it is a floating population and changes from month to month and it is also a queer custom of human nature that where many are left to accomplish something with no supervision, nothing is done. As they are not land owners, but merely renters, they feel little or no responsibility toward cleaning up their common grounds.

On the other hand in some of the Sonora Town courts in the old adobes, the rooms and beds are disgustingly dirty. Frequently our patients in the Obstetric Department of the Medical College, live in tents and their bed consists of a pallet or blanket thrown upon the ground. The conditions under which babies are born in some of these places are simply indescribable.

The report states the population to be 312; this is probably low as the inspectors counted only the house-holders in this district. I think I am safe in saying the population is between four and five

hundred, as visits from relatives are frequent, as they come from the ranches to find employment in the city. Probably 2500 people all told live under these conditions, not including those in lodging houses.

The situation resolves itself into one of sanitation and the proper construction of dwellings. Scrap iron, bagging, old lumber, and dilapidated tent flies make neither fire nor rain proof buildings. Imagine a fire starting some windy night in this district. The whole place would be wiped out in 30 minutes, with appalling loss of life. Consider the condition of any of these courts during our rainy season; paths mired into bog holes, roofs leaking, rain and wind beating into side walls, floors wet, bedding and clothes damp, stoves smoking, inhabitants sick with colds, easily developing into pneumonia! Consider the condition of delicate and already sick children and above all the father returning after a day's toil, to a home *with not one single home comfort*. Is it any wonder that vice, drunkenness and crime are bred under such conditions?

Is it any wonder that five murders occurred in Sonora Town during the month of September? Those who have been familiar with existing conditions have not been surprised at the high carnival of crime that has recently been raging throughout the city—crimes so atrocious that the police department has felt it necessary to institute extraordinary measures for their suppression.

Again look at the picture of drudgery imposed upon the woman. Imagine, as in Utah street, 8 *faucets* to supply the demands of 312 people, these faucets scattered at various points over an area of about ten 40 ft. lots. *Not one single inside faucet!* Every drop of water must be carried a greater or lesser distance for washing, cooking, bathing and drinking. Is it any wonder these people and children are dirty? Water,



to them, means a faucet, at some distance from their door, a nasty, muddy surrounding area and a certain amount of manual labor in procuring it. Under such circumstances pure water is no pleasure, no delight to them, as it is to us, furnished in any room of our house, we want it.

Their toilet facilities are not only inadequate, but in many cases are past description. They are used indiscriminately by both sexes; are seldom under lock and key and frequently without doors.

There is absolutely no more pitiable picture than when sickness attacks such homes. They are an ignorant, superstitious people and hard to deal with and a vast amount of tact must be used to gain their confidence. Here they lie, suffer and pass to the world beyond; too poor to pay for medical attention; too poor at times to pay for medicine that may be prescribed; surrounded by squalor, misery, bad air, insufficient food, and all the woes of poverty.

What can a Housing Commission do to alleviate such suffering? You say we already have a Board of Health, a city physician, visiting nurses, a County Hospital, an Associated Charities Organization and the various church societies. Is it possible you consider them sufficient to cope with all conditions, knowing their already over-taxed powers? These organizations deal with *existing conditions*. A Housing Commission works in conjunction and in harmony with them all, but its aim is *prevention*. We want proper homes, proper sanitary conditions, plenty of air, plenty of light, plenty of water.

Los Angeles needs to-day a system of legislation and inspection to arrest the development of improper buildings. New codes must be devised providing the best standards of lighting, ventilation, plumbing and fire protection. The

Health Board must be granted increased powers as to alteration or destruction of unsanitary and dangerous buildings.

We want to avoid over-crowding and develop the sanitary condition of the whole city upon a higher plane and thus lessen disease, decrease crime and educate these unhappy classes to become useful and intelligent citizens with a sense of home pride, rather than be mere drift-wood on the slime of the city's cess-pools.

We need the active interest and support of every man and woman in this city. To accomplish results time and money must be expended. The members of the Commission are serving without compensation, deeming this an opportunity for public-minded citizens to accomplish good for the future of the city they love. We have present conditions as well as future to meet, and the moral and physical welfare of beautiful Los Angeles depends upon the public spirit displayed by her citizens *right now*, before this state of affairs is irrevocably engratfed upon the city.

We need at once an experienced inspector, preferably one who is familiar with housing conditions in other cities, for the carrying on of our work. Mr. Veiller writes, and Miss Kenney who was east a few weeks ago and met Mr. Veiller and other prominent members of various Housing Commissions reports, we can do little unless our work is augmented by some one who is familiar with existing conditions in other cities, who will help us and develop our working basis. This may seem absurd, but it has been the experience of *every Commission* by their reports, throughout the United States. They all mention this fact, lay stress upon it, and advise future Commissions not to undertake the work blindly, but to be guided by their experiences and em-

ploy an assistant familiar with the work as an aid. This saves time and money; and can we afford to ignore their warnings?

The necessary funds must either be furnished by the municipality or by money raised by popular subscription. Again we might follow the Octavia Hill Association of Philadelphia and organize a stock company that will pay a small dividend upon the capital invested, for the erection of properly constructed dwellings, their maintenance, and the managing of outside property interests, that might wish to turn over the care of their property to the Association.

London and New York are fighting the tenement problem with great expenditure of money. London has just cleared twenty-two acres of land and rebuilt. "And in the most crowded region of London, to clear and rebuild twenty-two acres was indeed a gigantic task." New York is waiting and planning for the Phipps model.

A careful study is now being made of existing conditions and though the Commission have been dismayed by the

magnitude of the work right here in our own home city, we are by no means discouraged and hope to accomplish many needed reforms. Inspection must be carried on thoroughly and systematically. Ordinances must be framed and passed correcting existing evils and preventing those of the future, sanitation must be studied and improved, over-crowding both as to rooms and proximity of buildings must be looked out for. In short, the work is of such a character and of such vital importance to a progressive city, that it must be done in no slipshod manner, but thoroughly and scientifically, if we expect to accomplish any real and lasting results.

The members of the Commission can not do it all! We are doing our part, but in the very near future the minutia of the work must be put upon a financial basis, for its proper carrying on and for the attainment of lasting results. When the time comes, will you, each and every one, do your part to better the surroundings of these unfortunate people, within our city gates?

## TUBERCULOSIS DISEASE OF THE SPINE.\*

BY P. C. H. PAHL, B.S., M.D., LOS ANGELES.

Percival Pott, in 1779, described a disease which resulted in deformity of the spine, slow in formation, accompanied by pain and sometimes by paralysis. This, being the first accurate description of the condition, caused it to be known as Pott's disease. It does seem somewhat remarkable that this rather common malady has been understood only one hundred and twenty-seven years, when we read of operations for the cure of its resulting deformity as early as four hundred years before Christ.

It is not the purpose of this paper to set forth anything new or original, but simply to call attention to a few of the early symptoms, make a plea for a more rigid examination of children who are in a poor state of health and suffering from obscure pains, awkwardness in their movements, irritability or debilitation, and to discuss a few of the simple and effective means of treatment in these early cases.

Perhaps the most important point in connection with the diagnosis and treatment of Pott's disease is the thor-

\*Read before the Los Angeles County Medical Association, October 19th, 1906.

ough understanding and realization that it is pre-eminently an inflammatory condition and that it is attended by all the symptoms and characteristics of bone inflammation—pain, fever, muscle spasm, loss of function, and so on. The inflammation being, principally of bone and cartilage, implies that it follows a chronic course.

Pain in Pott's disease ranges practically from slight uneasiness to the most excruciating in character. It may be situated at the seat of the disease but it is much more frequently located at the termination of the spinal nerves which are involved.

The twelfth dorsal vertebra is most frequently the seat of the tuberculous inflammation; next in frequency are the two dorsal vertebrae above, and then, the two lumbar vertebrae below. For this reason the pain in Pott's disease is most commonly mistaken for stomach-ache, as the ninth, tenth, eleventh and twelfth dorsal nerves supply, practically, the entire abdominal region. The next most frequent pain symptom is what is often mistaken for sciatica; as a matter of fact, the pain is usually in front of the limb along the course of the anterior crural. In the upper cervical the pain may be mistaken for ear-ache. These differently situated pains are all aggravated upon motion of the spine or upon receiving a jar, especially those which come unexpectedly to the patient.

Fever is always present in the afternoon and is frequently met with in the morning; it is most commonly about 101 degrees in the afternoon. In very acute cases it may go to 104 degrees in the afternoon and 102 degrees in the morning. The temperature is very persistent, a slight degree often keeping up month after month, even when every other symptom has entirely disappeared; as long as it exists, however, the most rigid and careful treatment must be pursued.

Loss of function, I think, is by far the most important symptom of the disease, as it leads the parents or the physicians to further investigation which may result in the correct diagnosis. Loss of function is brought about by muscle spasm and pain, true to the same rules which govern the condition of muscle spasm in other parts of the body; for example, the blepharo-spasm when an irritation exists in the eye, the muscle spasm of appendicitis, the spasms of gall bladder disease or those in joint inflammation of the hip, knee, etc.

It is recognized by faulty attitudes, by an inelastic, rigid gait and by rigidity of the regions affected. In the dorso-lumbar region this is shown by the inability to stoop; or while lying prone and the feet and hips are elevated above the shoulders, there is loss of the normal elasticity of the spine. In the cervical region, besides the limitation of extension and flexion, the rotation of the head is also lost. Among the many remaining symptoms which are more or less constant, may be classed night cries, angular deformity, grunting, sometimes grunting respiration, paralysis, clonus, increase in knee jerk, psoas contraction, variously discharging abscesses and tumefaction in the iliac fossa, due to the collection from a tubercular abscess.

Pott's disease should be suspected in a child who moves about in an awkward and guarded manner, supporting itself by the hands or elbows on objects about the room or on its own thighs, and one who, when attempting to pick up articles from the floor, squats instead of stooping. Suspicion is also aroused in cases of acute torticollis and in children who support the head with the hands as well as those who are especially irritable.

In examining a child for Pott's disease it is necessary to carefully inquire into the personal history of the



patient, as to how long it has been unwell, if it has received an injury, if it has night cries or labored breathing, or if it has been associated with anyone who has pulmonary tuberculosis. Inquiry should also be made as to whether it has had pain and, if so, where situated and whether it has recently had any acute diseases such as typhoid. Family history should be carefully inquired into for tuberculosis. The child's clothing should be removed, and the temperature taken per rectum; if there are no contra-indications the child should be made to walk, in order to observe the gait. If dorsal or lumbar Pott's is suspected, the child should be induced to pick up objects from the floor and, when it goes to its mother or nurse observe if it supports itself by its hands. In cervical disease observe if the child readily rotates the head; or upon placing it on a table, with the head hanging over the edge, observe if the head hangs freely in a limp manner, or if it is rigid and causes pain. The child should be weighed and measured for height and circumference of the head and chest, and comparison made with the table of normal weights and measurements for children, to see if there has been any arrest in development.

Angular deformity is always looked for as well as clonus, increase in knee jerk, and iliac tumefaction. The history of pain should be very carefully inquired into and close observations made as to whether it is increased by walking or when the spine is caused to exercise its normal functions such as extension, flexion and rotation. I have observed that the pain frequently indicates the segment affected by running a vibrator up and down the spine.

It is not to be understood that the child is to be subjected to unnecessary ordeals which may cause an acute exacerbation to follow the examination. The skillful diagnostician handles the

child so gently that it is not caused any discomfort, and employs only such tests as are absolutely necessary to satisfy him in regard to the conditions present.

If it is impossible to make a diagnosis by these means a tuberculin test should be made. In two cases resorted to by myself, it yielded the following results:

First. A boy, six years of age, weight 35 pounds, height 40 inches. He was given five milligrams of tuberculin at 9 p.m., the temperature being 101; gave a reaction in ten hours of temperature 105, which went down to 101 in eighteen hours.

Second. A young woman, twenty years of age, weight 101 pounds, height 65 inches. She was given ten milligrams of tuberculin, temperature 99.5; in six hours the temperature arose to 103, where it remained for four hours and, in the next two hours it came down to normal. There was a slight increase in the white corpuscles during the reaction.

In three negative cases there was practically no reaction.

#### TREATMENT.

The treatment in early Pott's disease is very simple and, when carried out with any degree of persistency, is most satisfactory. The difficulty does not lie in not knowing what to do, but in persuading the parents that certain radical means are necessary and in overcoming the thousand and one obstacles that seem to stand in the way of carrying out those methods of treatment known to be most successful.

It is a deplorable fact that, in those cases where they are liable to be sick for a period of years, it is almost impossible to control the patient until a cure is finally effected. They are liable to go from one doctor to another, and I have never had, or have never heard of a case, where there are not some friends of the patient who practically

insist upon the child being taken to an osteopath. This being a bone disease and frequently accompanied by deformity, parents naturally think of this class of practitioners.

Therefore, taking all things into consideration, the eventual outcome of a case of Pott's disease depends very much upon the integrity and intelligence of the parents and, to no small degree, upon their financial circumstances. 'I have found, in hospital practice, that it costs from \$50 to \$75 a month to care for a child suffering from this malady. When the child is cared for at home, it can usually be done at an expense of about \$15 or \$20 a month, as it is necessary for the physician to visit the child at least once a week.

In ninety per cent. of the cases, Pott's disease occurs under the tenth year, frequently between the ages of three and five. This goes to show that it is pre-eminently a disease of early childhood occurring in those years when a disturbance in the natural process of development will make a marked difference in the individual when maturity is reached. It behooves us, therefore, to adopt such lines of treatment as will interfere least with the natural growth. It is almost impossible to apply any kind of apparatus to a child which will not leave its blasting effect. Observe, for instance, the receding jaw where jury masts have been worn, and the contracted cylindrical chest resulting from the continued wearing of corsets and braces. If the child is placed on the scales it is found to be many pounds under weight and the measurements for height and chest circumference are also very much diminished.

I do not mean to say that there exists any method of treatment whereby the child will not be undersized and show some marks of the apparatus employed, but I do believe that it is our duty to reduce these to the minimum. I think, probably, that it has been our

mistake in the past to try to do too much or to do impossible things, that is, to attempt to treat a case of tuberculous disease of the spine in the early stages and, at the same time, to allow the patient to walk. It is readily evident that it would be much harder to prevent deformity in a method of treatment where the spine is required to carry the weight of the head, and, in some cases, the head, chest and upper extremities, than by a method whereby these are placed at perfect rest.

It is a difficult matter to convince the parents that it is not at all necessary for the child to walk for a period of from six months to a year, and that the child cannot spend its time to better advantage than to give itself up entirely to the object of getting well, but this is the first stage of the treatment. The condition of the child must be thoroughly explained to the parents; they must be told that the child is afflicted with a very serious disease, which, if not very carefully and persistently treated, may result in the child's death or certainly in making it a cripple for life. These facts cannot be too forcibly impressed, and there must be a thorough understanding as to the means necessary and the length of time required to effect a cure before the treatment is begun. These points having been settled, the treatment proper is begun. First, the length of the child is determined, and the width across the chest. A gas-pipe frame is then ordered; this measures six inches longer than the child and the exact width of the chest. If for a child about five years of age, this is best made of one-quarter-inch galvanized gas pipe and will measure seven inches wide and forty-eight inches in length. Next are ordered two pieces of twelve-ounce canvas measuring thirteen by fifty inches, with grommets every three inches along each margin and sufficient rope to lace one of these covers over

the frame; the extra cover is for the purpose of changing. Two child's waists are then ordered. Two pieces of felt are also necessary; they are one inch thick, two inches wide and six inches long. These and the waists are sewn on the canvas in such a manner that the felt pads lie under the transverse processes of the vertebrae, leaving an inch between them so that the spinous processes of the vertebrae affected will not receive any of the body weight, for pain and perhaps a decubitus would soon follow if they did.

The waist is so adjusted that when the affected vertebrae are properly placed upon the pads, it fits the arms and chest. The frame is next bent slightly, at the point of the disease, so as to make a double inclined plane of the apparatus in order that the diseased bodies of the vertebrae have a tendency to separate. The child is then placed upon the frame naked, a towel is pinned tightly about the pelvis and necessary additional clothing is placed over the child, frame and all. This method of treatment was devised by Dr. Edward H. Bradford of Boston, and the frame justly bears his name, being known as the Bradford frame.

The child stays upon this frame twenty-three hours out of the twenty-four, being taken off for one hour in the morning when it is bathed and massaged. This is best done on a table upon which a blanket has been placed. The child receives six feedings a day. At six in the morning it has a mixture consisting of four ounces of milk, two ounces of cream and one raw egg; its breakfast is served at eight, and at ten o'clock it is given two ounces of beef juice expressed from round steak in a meat press; this juice is slightly warmed, not enough to coagulate the albumen, and seasoned with pepper and salt. At 12 o'clock the child has its dinner, at three in the afternoon a mixture of milk,

cream and egg is given, and at 5 o'clock, supper; at midnight, or sometime during the night, it is given a glass of good milk.

The regular meals such as breakfast, dinner and supper, must be selected according to the condition of the patient.

The patient spends at least six hours a day out of doors; three in the morning and three in the afternoon during the most favorable hours. Where it is possible, it is best kept out of doors all of the time. The medication is limited, practically, to laxatives and tonics and those to be given sparingly; the child is not to be burdened with cod liver oil, phosphates and the endless array of so-called tissue builders.

The temperature and pulse are taken every morning and evening and a close watch kept of the bowels. This treatment is continued until all symptoms disappear and the temperature has been normal for at least three months and the child has every appearance of perfect health. It is then allowed to be off of the frame for two hours in the twenty-four; it may roll about on a rug in the presence of the mother or nurse. Two weeks of this and another hour is added; it may then be allowed to creep, but not to stand. After a month of this treatment a rigid corset, which laces, is applied and the child is allowed to play about and stand and walk from two to five hours a day; the rest of the time being spent on the frame. If the child shows no symptoms such as temperature or pain at the end of two months, it may then remain off of the frame all day and sleep on the frame at night. At the end of three months from this time, if it continues to do well, the frame may be discarded, the child wearing the corset during the day only. After six months time, a recovery brace may be substituted; this is worn for an indefinite time.

I consider this method of treatment



an ideal one and believe it should be carried out whenever possible. This is the only method known to me whereby a child can be treated for Pott's disease and get well without deformity, or, if deformity exists whereby it can be materially reduced. The children are larger and healthier; they do not get the peculiar disposition that Pott's cases usually have. I have never observed the development of abscesses or paralysis where this method of treatment has been employed.

The objects to be attained in this treatment of Pott's disease are all admirably accomplished—the almost complete suspension of the function of the diseased part so that the opportunity for the child to receive injuries is reduced to the minimum; and it is possible for the child to receive daily baths and massage without any especial irritation to the regions affected, and finally it not only prevents deformity, but lessens that which already exists.

The diet, which is one of the chief features in the treatment of Pott's disease, can be perfectly controlled. Another feature of this treatment is the fact that there is no pain in the adjustment or during the course of the treatment; and the patients, as a rule, are all comfortable and very happy.

But pain is perfect misery, the worst of evils, and excessive, overturns all patients.—*John Milton*.

If the baby vomits, don't put anything except water into his stomach for four hours.

The salicylate of strontium is an intestinal antiseptic and anti-rheumatic, dose 10 to 15 grains.

A solution of salicylic acid (1 to 500) is useful as a gargle and mouth wash in diphtheria.

In protracted cases of summer complaint give freshly pressed grape and other juices to prevent scurvy.

As an all around vaginal douche nothing will equal two drams of Pearson's creolin in 1-2 gallon of water, says Dr. Fennel.

In excising a varicocele under local anesthesia, tie the upper ligature first; the pain of tying the lower ligature will then be abolished.

In prolapsus recti, Dr. Butler recommends strychnine internally or by hypodermic injection into the subcutaneous tissue of the rectum.

Atropine in solution is an excellent remedy for earache. A drop or two of a solution of four grains to the ounce of water will be sufficient.

*Aletris farinosa* is especially indicated where abortion is feared, in which cases it should be continuously administered during entire gestation.

*Alstronia scholaris* is highly recommended in chronic diarrhea and dysentery, and as a tonic in convalescence from exhausting diseases.

In gastric disorders, where flatulence is troublesome, if bicarbonate of soda used as an antacid increases the flatulency, use bismuth.

Hiccough in infants can be cured by fastening a bandage tight around the stomach, restraining the diaphragm.

Ammonia is said to be a good and ready antidote in formaldehyde poisoning.

Castor oil, washed with hot water, sweetened with saccharine and flavored, loses its characteristic taste.

Peach-root tea, three or four ounces of the infusion daily, is stated to have cured epilepsy.

Sulphodide of bismuth dusted on an oozing granulated wound promptly stops the bleeding. It is also an excellent stimulant to the growth of epithelium.

# SOUTHERN CALIFORNIA PRACTITIONER

A MONTHLY JOURNAL OF MEDICINE AND ALLIED SCIENCES.

Communications are invited from physicians everywhere; especially from physicians on the Pacific Coast, and more especially from physicians of Southern California, Arizona and New Mexico.

DR. WALTER LINDLEY, Editor.

DR. F. M. POTTENGER and DR. GEORGE H. KRESS, Assistant Editors.

DR. H. BERT ELLIS, DR. GEO. L. COLE and DR. W. JARVIS BARLOW,

Associate Editors.

Address all communications and Manuscripts to

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## EDITORIAL.

### THE 1906 INDEX OF THE PRACTITIONER.

This issue of the PRACTITIONER prints the index of its contents for the current year. An effort has been made to have this index be an accurate list of all articles and topics considered, as well as to include the names of all contributors and all physicians to whom reference was made.

The purpose in doing this is to fulfill one of the ends of this publication, that is, that it shall not only be a reflex of the scientific activities of the medical profession of the Southwest, but that it shall also be a fairly accurate historical exponent of the profession of this Section.

Some of our readers may have noticed that during the last year, we have printed on the rectangular edge of the outer covers, in addition to the volume and date of issue, the pages included in each issue. To the December

issue we have added the word INDEX NUMBER. By this means, it is possible by reference to the Index to find the page of any article and then, by allowing the eye to run down the column of pages on the back of the covers, to pick out the issue containing the pages wanted.

In other words, this simple addition does away with the necessity of binding the PRACTITIONER and at the same time makes it quite as accessible for reference use.

It was our privilege to make and to see this suggestion adopted by the *Journal of the American Medical Association* a year or so ago, and we have wondered why other publications have not taken up so simple an innovation, which allows one to preserve for future use, without extra expense, the most recent medical literature, which, if left in the ordinary unbound folios, would soon be consigned to garret, cellar or furnace.

# THE RECENT MEETINGS OF THE SOUTHERN CALIFORNIA MEDICAL SOCIETY AND THE SOUTHERN CALIFORNIA ANTI-TUBERCULOSIS LEAGUE.

Two recent meetings of considerable interest to the profession south of Point Concepcion, were those of the Southern California Medical Society and the Southern California Anti-Tuberculosis League, the proceedings of which are considered elsewhere.\*

At the Southern California Medical Society a valuable and instructive series of carefully prepared papers, which were well discussed, were presented. The attendance was quite good and the meeting was brought to a fitting close by an excellent banquet at the Angelus Hotel.

The Southern California Anti-Tuberculosis League also held its meeting at the Angeles. The annual election of officers and reports of officers and of institutions devoted to the prevention and treatment of tuberculosis, constituted the work of the meeting. It was gratifying to hear the reports of the Redlands Settlement, the Pasadena Helping Station, the Barlow Sanatorium of Los Angeles, and the Helping Station of the League, in Los Angeles, and to note the active efforts being made in the South to combat the great white plague.

Both meetings did much for Southern California and the medical profession, not only along scientific lines but in the development of the social relations, and of that united effort, which are so necessary to the attainment of results in all scientific upbuilding, and in all work connected with the protection of the public health.

# THE PUBLIC HEALTH DEFENSE LEAGUE.

In a somewhat recent issue of the PRACTITIONER, reference was made to a medico-legal address by the Hon. Champe S. Andrews, Counsel of the Medical Society of the County of New York, who had been waging a fierce warfare against quackery and charlatan-ism, in that city, and who advocated the formation of a national society, open to both laity and medical men, if the patent medicine evil and quackery were to be abolished.

It is pleasant to know and a good sign of the times, one that bodes much for the future, that this agitation for such a society was not in vain. Several weeks ago representatives of more than 150 medical, philanthropic, religious and charitable associations met at New York and formally organized an association, chartered upon lines similar to those of the American National Red Cross Society. The purposes and objects of the corporation are and shall be:

"(a.) To obtain and disseminate accurate information concerning practices and conditions of every kind that are dangerous to the public health and morals, and to work for the enlightenment of the public on all matters affecting these subjects.

"(b.) To work for the enactment of laws in the United States, Territories, and colonial possessions, for the protection and preservation of the public health and morals, including those matters mentioned in sub-division (c) hereof.

"(c.) To assist the constituted authorities in the enforcement of all laws affecting the public health including



those laws for the prevention of quackery, charlatanism, and criminal practices in the healing art, whether by licensed or unlicensed practitioners; the prevention of adulteration and substitution of drugs and food and food substances; the prevention of the sale of narcotics, alcohol, and dangerous substances of every kind, whether under the guise of proprietary remedies and so-called patent medicines and nostrums and remedies, or whether sold as narcotics in violation of law; the prevention of the admission to the United States mails of all newspapers and printed matter of every sort advertising any business injurious to the public health or morals, and to prohibit the advertising of such business in any way.

"To oppose and work against the pas-

sage of laws detrimental to the public health and morals, to work for the repeal of any law having such an effect; and generally to institute proceedings in law and equity to carry out the objects and purposes of the corporation.

"The name of the new society will be the Public Health Defense League.

"The dues of this Society are not to exceed one dollar per annum."

The League begins its career under excellent auspices and should receive the full support of the medical profession. It would be hard to place a dollar in a better cause than this. Full information may be obtained from the Secretary of the Public Health Defense League, 37 Liberty Street, New York, to whom remittances for membership may also be sent.

## EDITORIAL NOTES.

An Emergency Receiving Hospital is about to be established in Pasadena.

Drs. Granville MacGowan, J. De-Barth Shorb and John R. Haynes have returned from their European trips.

Drs. Everett R. Smith and John R. Colburn have returned from their Oriental tours with interesting observations.

Dr. Lewis R. Brown of Bisbee, Arizona, has been visiting in the city of Mexico.

Dr. Miriam Gardner, of Pasadena, has returned from several months work in the hospitals of Europe.

Dr. James Louis Pratt, aged 74 years, died November 27th, at his residence in San Bernardino.

Dr. John L. Norris, the Santa Fe surgeon of Estancia, was recently called professionally to Tucson.

The auto of Dr. H. G. Atwater, of

Los Angeles, was recently upset near Riverside, nobody hurt.

Dr. Thomas Michaels of Torrance was recently called professionally to Santa Fe, New Mexico.

Dr. E. T. Dunaway, formerly of Murray, Kentucky, has located in Roswell, New Mexico.

Dr. W. R. Tipton of Las Vegas, New Mexico, has returned from a professional trip to Chicago.

Dr. F. E. Shine of Bisbee, Arizona, recently made a brief trip to Los Angeles and vicinity.

Dr. Ira E. Brown of Keldan, Arizona, was recently called professionally to Florence.

Dr. Charles G. Stivers, of Los Angeles, has returned from several weeks work in the hospitals of Chicago.

Dr. C. W. Lawton of Long Beach,

who has been absent on a trip to Seattle, has returned home and resumed his practice.

Dr. Herbert Waterhouse, of Pasadena, returned from Chicago on Dec. 6th.

Dr. E. N. Mathis has resigned from his position as health officer of Los Angeles County and will in the future devote his time to mining interests.

Dr. L. M. Powers, health officer of the city of Los Angeles, has been investigating matters especially connected with his work in New York City.

Dr. W. H. Kiger of Ocean Park, Los Angeles County, has been spending several weeks in hospital work in the East.

Dr. James P. Booth is contesting the election of Dr. R. S. Lanterman as coroner of Los Angeles County. The official count gave Lanterman 435 votes more than Booth.

Drs. Rea Smith, Guy Cochran and Edward J. Cook have returned from a trip east, during which they stopped for some time in Rochester. They had a most enjoyable and profitable time.

Dr. G. E. Bridge, of Bisbee, Arizona, became a hero recently by hanging on to a fractious horse inclined to a buggy containing two children.

Dr. O. N. R. Stafford was recently appointed health officer of the County of Los Angeles. Dr. Stafford graduated from the College of Medicine of the University of Southern California in 1901.

Dr. John A. Colliver has returned to Los Angeles after an absence of several months in New York City where he has been doing special work in the Children's Hospital and the Vanderbilt Clinic.

At a recent meeting of the Grant County, New Mexico Medical Society, held at the office of Dr. G. K. Angle, Dr. J. G. Holmes of Pierre was elected to membership, Drs. Angle, Millikan

and Leg were elected as a Board of Censors.

Dr. W. D. Radcliffe of Belen, Dr. B. D. Black of Las Vegas, Dr. T. B. Hart of Raton, Dr. G. W. Harrison of Albuquerque and Dr. John T. Pearce of Albuquerque have all been attending the semi-annual meeting of the territorial Board of Health at Santa Fe, New Mexico.

On Tuesday, December 11th, Miss Laura Brown, M.D., and Harvey J. Hall, M.D., were married at St. Vincent's M. E. Church, Los Angeles. They are both graduates of the College of Medicine of the University of Southern California and each had received the degree of A. B. before beginning their medical studies.

On December 12th, Dr. Arthur F. Godin and Blanche Kimball were married at the residence of the bride's parents in Patton. Rev. William Horace Day, of Los Angeles, was the officiating clergyman. Dr. Godin is one of the rising young physicians of Los Angeles. The young couple will be at home to their many friends at 744 Beacon Street.

Drs. E. L. Leonard and L. B. Stockey have established laboratories at 630 and 632 Auditorium Building, corner of Fifth and Olive streets, where they are prepared to examine Pathologically, Bacteriologically, Microscopically and Chemically, blood, urine, faeces, stomach contents, sputum, uterine scrapings, pus, transudates and other tissues and fluids of the body for diagnostic and other scientific purposes.

Just as we go to press a decision has been rendered by the District Court of Appeals that the Legislature of California has no right to delegate its authority to the State Board of Examiners on the ground that it is unconstitutional. The decision was in regard to the case of Dr. James T. Arwine of Long Beach, who for five years was a

surgeon in the army. The Board refused to give him a license to practice in California. The Court ordered the Board to issue the license forthwith.

Dr. S. A. Knopf of New York City, in an address before the Laennec Society for the Study of Tuberculosis of Johns Hopkins Hospital, says: "Whatever prevents the development of tu-

berculosis will prevent social misery; whatever cures it will help to cure the social ills. Inasmuch as we diminish tuberculosis among the masses we will diminish suffering, misery, and social discontent, and when the problem of tuberculosis will have been solved, we will be nearer the millennium than we have ever been before."

## TWENTY-ONE YEARS AGO IN LOS ANGELES.

EXCERPTS FROM THE SOUTHERN CALIFORNIA PRACTITIONER, VOL. I, NO. 12, DECEMBER, 1886.

*Excerpt from an original article entitled "SOUTHERN CALIFORNIA—A CLIMATIC SKETCH," by Walter Lindley, M.D.*

"In acknowledging the great honor that you, through your president, Dr. Fowler, have conferred upon me by inviting me to address you this evening, I can not tell you of a country where a man with incipient phthisis can go and spend three months, return to the environments that produced his disease, and be a well man. But I shall tell you of a land containing cities and plains, mountains and valleys, oceans and rivers, meadows and deserts, the rose and the cactus, pine forests and orange groves, where the person in the first stage of phthisis may go, make a delightful home for himself, and in time become a man of average health; a place where the child of a phthisical parent will usually develop into healthy manhood.

"Many patients with incipient phthisis are told to go and spend a few months at some popular resort. They should be told to go until they find a climate that suited them, and then remain there. It should not be pictured to them as a holiday vacation, but rather as a long struggle for life. . . .

"But your health resort may have a mild and equable temperature, a proper altitude, a pure atmosphere; and yet, if

it has not variegated scenery and pleasant social surroundings, the health seeker will die of ennui.

"This is the point in which Los Angeles, as well as many other places in Southern California, is most happily endowed. A thriving city of 45,000 inhabitants, with satisfactory hotels, boarding houses, and restaurants; excellent schools ranging from the kindergarten and public schools to colleges, a state normal school, and a well equipped university, a commercial metropolis with the ocean at its door, and the center from which radiate seven lines of railroad; with cable roads that noiselessly carry people from the busy streets over the hills to the suburbs; lighted 340 days in the year by the sun and 365 nights in the year by electricity; elegant churches in which worship Roundheads and Cavaliers, the Salvation Army and Unitarians; an opera house fully equal to any in the city of Brooklyn, in which are to be seen during the year all the leading theatrical attractions of America, ranging from the irrepressible New York negro minstrel troupe to that "noblest Roman of them all," Lawrence Barrett; from the vivacious Rhea to the histrionic Janaushek; the home of the rose, where the humblest cottage is surrounded by a perpetual flower garden; where heliotropes and fuchsias clamber



to the tops of the houses and there bloom in all their beauty the year round.

"I shall now say a few words in regard to the benefits derived from the climate of Southern California—no statistics, but simply a few thoughts the result of my own observations.

*"Diseases of Children.*—There, summer disturbances of the intestinal tract are never prevalent. I have been physician to the Los Angeles Orphans' Home for the last six years, and, although there are about eighty inmates, many of them under two years of age, yet in all that time there has not been a death from the so-called cholera infantum or any disease of a similar nature.

*"Dyspepsia.*—Dyspeptic persons are almost invariably relieved, owing in part, to the character of food always available.

*"Malarial Diseases.*—Intermittent fever never develops in Los Angeles county. I speak thus positively because my experience as Health Officer of the city of Los Angeles, Attending Physician to the Los Angeles County Hospital of 100 beds, as well as my private practice, justifies me in the statement.

*"Hay Fever.*—A few months since I became interested in this subject, and, after corresponding with fifty of the leading physicians in the counties mentioned, arrived at the following conclusion:

"1. Hay fever never originates in Southern California.

"2. All persons with hay fever that have come, seeking relief, to Southern California, have been benefited; almost all have been cured.

"3. That a few miles inland, in the foothills, relieves such as are not benefited by a residence at the seaside."

*"Asthma.*—The great majority of persons affected with this disease can get permanent relief within a radius of sixty miles of Los Angeles.

*"Senility.*—This is a paradise for per-

sons who have passed the meridian of life.

*"Nervous Prostration.*—Persons in this condition receive benefit from the pleasure of out-door life and refreshing sleep that comes at night.

*"Chronic Rheumatism.*—Besides the beneficial effects of the climate on this disease, there are a great variety of mineral springs, hot and cold, that have quite a local reputation, and about which an interesting volume might be written.

*"Phthisis.*—Within a radius of ten miles of Los Angeles all the requirements mentioned by the distinguished authorities quoted above can be found in numerous points happily combined. Time does not permit me to give you reports of cases. It would take hours to report all the cases of physicians who have themselves gone to Los Angeles and other points in Southern California suffering from phthisis of various types and stages, and who are now following their chosen profession in apparent good health.

"A few years since the Legislature of California instructed the State Board of Health, of which the late lamented Dr. Henry Gibbons, of San Francisco, was president, to select the most favorable point for a state sanitarium for consumptives. After months of careful investigation they reported that the first place belonged to Sierra Madra Valley, 12 miles east of Los Angeles.

"My own experience has been that the great majority of patients with consumption do well in the immediate vicinity of Los Angeles, but that the best place is a few miles nearer the mountains, in altitudes ranging from 1000 to 2000 feet."

\* \* \*

*Excerpt from an original article entitled "NOTES ON THE CLIMATIC AND SANITARY CONDITIONS OF SOUTHERN CALIFORNIA," by W. M. Chamberlain, M. D., New York:*

"The increase and the diffusion of

wealth, the extension of railroads, and the greatly increased comfort of travel, have made us a traveling people. . . .

"Notably in the last few years this tide of travel has turned toward California, and during the last winter the southern part of that State was fairly inundated by it. For two months the Southern Pacific Railroad alone brought to Colton an average of more than a thousand west-bound tourists daily. . . .

"The Kuro-siro, or the Pacific Ocean current, corresponds to our Gulf Stream, issuing from the China seas, pursues a northwesterly course across the Northern Pacific and strikes the American continent on the coast of Alaska, which it covers with clouds and rain, as the Gulf Stream does the western coast of Great Britain, Ireland, and the Orkney Isles. It also raises the temperature remarkably, so that the mean winter temperature of Sitka is nearly the same as that of Baltimore.

"The return current, together with a deflected portion of the original current passes down the coast of Oregon and California, at a distance from the coast increasing as it goes southward. It is desiccated as it goes, by precipitation. It gives Oregon 50 to 60 inches of rain annually, Northern California from 30 to 40, and Southern California from 10 to 20. At point Anuelo, having now lost most of its force, it is shouldered off the coast, leaving the embayed shore of Southern California washed by the warmest waters of the subtropical sea, driven thither by almost uniform southwest winds, of little force in winter but strong in summer.

"The distribution of ground-water is peculiar and interesting. You may enter a basin-like depression in the hills, containing perhaps several square miles of alluvial plain. It may not be traversed by any stream; there is no visible outlet for water, and you wonder what becomes of all that falls on the

long slopes which surrounds it. It has, in fact sunk into the surface when it fell, and descended, to underlie the plain at a depth often of not more than eight or ten feet. Such plains, except in the rainy season, look dry and parched; still they are set with great sycamores, evergreen live-oaks, and rapidly growing groves of eucalyptus, as well as orchards of fruit trees. The young plants may require to be irrigated for a year or two, but soon their roots reach down to the unfailing streams below, and thenceforth they require no artificial water. After the third year the vineyards in such localities are full of lush leafage and succulent fruit, and the wells about the farm are full to within ten feet of the surface. . . .

"From many sides we gather the inference that there is something in the air and soil of Southern California which nourishes, improves, and prolongs organic life to a remarkable degree.

"The eucalyptus tree adds from eight to twelve feet annually to the length of its trunk. . . .

"In my judgment Pasadena is the point of election for, by far, the larger number of invalids. Especially do the conditions before enumerated fit it for all cases of renal diseases, all cases of pulmonary trouble attended with free secretion, for enteric, rheumatic and neuralgic affections. . . .

"In these days of mind-cure, faith-cure, and subjective medication generally, one of the best things that can be said of Southern California is that it is an eminently cheerful region. Nostalgia and hypochondria cannot well continue here; there is too much enterprise, too much pleasure abroad. I have never seen so many contented people so far away from home.

"It is common among the older residents to speak of it as 'God's Country,' which may sometimes be a way of com-

plimenting the Elysian climate and the bountiful soil, but is oftener, I think, a more serious recognition of the Power and Light which builds and adorns the Cosmos

"Which wields the world with never-varying love,  
Sustains it from beneath and kindles it above."

\* \* \*

*Excerpt from an EDITORIAL NOTE:*

Dr. John L. Davis read a very able comprehensive paper on "SOUTHERN CALIFORNIA FOR HEALTH," before the Cincinnati Medical Society, in which he says:

"A fuller investigation of the subject shows that California and the whole Pacific Slope is probably more richly endowed with medicinal waters than is any other region of the world; there are here every variety of tepid and hot springs, alkaline and saline waters of every description, chalybeate, sulphur and calcareous waters, containing their salts in various proportions and combinations. . . .

"The various elements enumerated combine to make Southern California probably the most attractive healthy region in the world, and it has been predicted that as its advantages are more fully understood the State will become the health resort of the world; even now many European physicians are recommending its climate to their patients, and Americans are awakening to the fact that they have at home a region for invalids better than any single locality abroad.

"Aside from persons seeking health in this favored land, many go there for comfort and pleasure not to be found elsewhere, and as a result the State is filling up with a class of people who for intelligence, refinement and social excellence are second to no community in the land."

*Excerpt from an editorial entitled "FLANNELS AND FIRE!"*

"The very mildness of a semi-tropic November makes it all the more necessary for anyone, and especially for the invalid, to be upon his guard. The days are so sunny and the mornings still so mild that the beginning autumn chill is hardly noticed, and flannels and fires are neglected until a heavy cold gives a warning not to be disregarded. And then the homely wisdom of one of Josh Billings's sayings is realized, viz: "A man's hindsight is much better than his foresight." . . .

"Invalids, feeble folk, draw all the health and vigor you can from the warm sun of noonday, and watch the oranges turning daily a richer yellow against their background of green, but don't forget when you go to your room as the chill of the evening comes on to shake the camphor out of your winter flannels and light a fire in the grate. And so may your days be long in the land, and far away skies of yet Novembers look down upon you while you walk the pathways of the living."

\* \* \*

*Excerpt from an editorial entitled "THE SOUTHERN CALIFORNIA PRACTITIONER OF 1887:"*

"With this issue we close our first year. Our editorial work, while performed with a sense of serious responsibility, has been really a recreation, respite from our professional duties. We have enjoyed it.

"We have realized pleasure in the fact that we have been assisting in making the history of the medical profession of the Pacific Coast. It has been a pleasure to us because we know we have published many valuable papers by physicians of Southern California that would have never been written had we not solicited them. We thank the medical journals of the United States and Canada for the generous treatment they have accorded us."



*Excerpt from an editorial entitled "THE COLLEGE OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA:"*

"The Medical College of the University of Southern California has rented a building on Aliso street for the last eighteen months, which has served the purpose very well, yet the faculty has recognized the fact that, if the class continues to increase in numbers as it has this year, a more commodious structure would soon be necessary. . . .

"With these thoughts flitting in a half defined way through the minds of the members of the faculty, they convened at their regular monthly meeting in November. After the routine business was transacted the Dean, Dr. J. P. Widney, stated that he had purchased the property now occupied by the college, and that it was the intention of himself and Mrs. Widney, as soon as the size of the class demanded it, to erect a three-story brick building for the use of the Medical College, and to present it to the University.

"Dr. Widney is but little beyond the age of two score years, and yet his life has been so crowded with noble, generous deeds that, should age be reckoned by a man's good works, he would indeed be an aged man. In

his many Christian acts, as well as in his scientific and literary labors, he has a sympathetic, intellectual, earnest co-worker in Mrs. Widney.

"May God spare both to witness a half century's work of the Medical College of the University of Southern California, is the prayer of every member of the faculty"

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*Excerpts from "EDITORIAL NOTES:*

Dr. William B. Bullard of Lincoln Center, Maine, paid us a pleasant call recently. His son Frank is attending the Medical College of the University of Southern California. . . .

\* \* \*

The *New York Evening Post*, of November 2d, under the heading of "An Earthly Paradise," republished from the *New York Medical Journal* liberal extracts from the paper of Southern California by Dr. Walter Lindley, which is to be found in full in this number of the SOUTHERN CALIFORNIA PRACTITIONER.

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We have through Dr. Orme, President of the California State Board of Health, received a letter from Dr. R. H. Plummer, saying that A. A. Graham of Reeding has been convicted for practicing without a license. . . .

## SOCIETY PROCEEDINGS.

### SOUTHERN CALIFORNIA MEDICAL SOCIETY

The Thirty-seventh regular semi-annual meeting of the Southern California Medical Society convened at Los Angeles, Cal., December 5-6, 1906, the arrangements being charge of a committee consisting of Doctors Thos. J. McCoy, Chairman, Wm. T. McArthur and Albert Soiland.

The first meeting was called to order by the President, Dr. Hoell Tyler, of Redlands, on Wednesday, December 5th at 2 p.m.

The complete program of the session was as follows:

WEDNESDAY, DECEMBER 5TH, 2 P. M.

President's Address, by Dr. Hoell Tyler, of Redlands.

THERAPEUTICS.

J. A. Champion, M.D., Chairman, Colton  
*Atropine*, by Frank H. Pritchard, M.D., of Colton.

*Discussion* opened by Dr. Champion.

MEDICINE.

Norman Bridge, M.D., Chairman

..... Pasadena

*The Best Bath for the Sick and the Well*, by Norman Bridge of Pasadena.  
*Some Observations on Recent Surgery of the Gall Bladder*, by Norman Bridge, of Pasadena.

## PATHOLOGY.

C. C. Browning, M.D., Chairman  
 ..... Monrovia.  
*The Borderline of Functional and Organic Disease*, by Earnest B. Hoar, M.D., of Pasadena.  
*Value of Anti-Toxic Sera*, by E. L. Leonard M.D., of Los Angeles.  
 Discussion opened by Dr. Browning.  
*Exhibition of Pathological Specimens*, by Stanley P. Black, M.D., Pasadena.  
 WEDNESDAY, DECEMBER 5TH, 7:30 P.M.

## SURGERY.

D. C. Strong, M.D., Chairman  
 ..... San Bernardino  
*Fractures of the Cranial Vault*, by D. C. Strong, of San Bernardino.  
 Discussion opened by W. P. Burke, M.D., of Highland.

## GYNECOLOGY.

Chas. D. Ball, M.D., Chairman  
 ..... Santa Ana  
*Primary Carcinoma of Uterus and Urethra in Female*, by C. D. Ball of Santa Ana.  
 Discussion opened by Geo. W. Lasher, M.D., of Los Angeles.  
*Results of Rontgenization in Superficial Types of Cancer*, by Albert Soil-and M.D., of Los Angeles.  
 THURSDAY, DECEMBER 6TH, 9:30 A.M.

## PUBLIC HEALTH AND HYGIENE.

W. W. Roblee, M.D., Chairman  
 ..... Riverside  
*Disinfection*, by W. W. Roblee, of Riverside.  
 Discussion opened by Stanley P. Black, M.D., of Pasadena.

## NERVOUS AND MENTAL DISEASES.

Robert L. Doig, M.D., Chairman  
 ..... San Diego.  
*Autotoxaemia* by Robert L. Doig, of San Diego.

Discussion opened by Thos. L. Magee, M.D., of San Diego.

## PEDIATRICS.

Charlotte J. Baker, M.D., Chairman  
 ..... San Diego.  
*Hypertrophic Stenosis of the Pylorus in Infancy*, by Wm. A. Edwards, M.D., of Los Angeles.  
*The Doctor and the Child*, by George E. Abbott, M.D., of Pasadena.  
 Discussion opened by F. R. Burnham, M.D., of San Diego.  
*Summer Diarrhea of Children*, by Louis Harvey Clark, M.D., of Riverside.  
 Discussion opened by W. W. Roblee, M.D., of Riverside.

THURSDAY, DECEMBER 6TH, 2 P.M.

## OPHTHALMOLOGY, LARYNGOLOGY, RHINOLOGY AND OTHOLOGY.

A. L. Macleish, M.D., Chairman  
 ..... Los Angeles.  
*The Contribution of Ophthalmology to the Diagnosis of Arterio-Sclerosis* by A. L. Macleish of Los Angeles.  
*Notes on Cases of Glaucoma* by L. S. Thorpe, M.D., of Los Angeles.  
 Discussion of both papers opened by B. F. Church, M.D., of Los Angeles.

## OBSTETRICS.

M. L. Moore, M.D., Chairman  
 ..... Los Angeles.  
*The Toxemia of Pregnancy* by M. L. Moore of Los Angeles.  
*The Care of the Parturient Woman* by Titian Coffey, M.D., of Los Angeles.

\* \* \*

The election of officers resulted as follows: President, C. Van Zwalenburg, M.D., of Riverside; 1st Vice-President, W. W. Roblee, M.D., of Riverside; 2nd Vice-President, George E. Abbott, M.D., of Pasadena; Secretary, Jos. M. King, M.D., of Los Angeles.

The next meeting will be held at San Diego, probably at the Hotel Coronada, if suitable arrangements can be made.

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The banquet held on Thursday evening at the Angelus Hotel, was a most

enjoyable and delightful function. The banquet hall was beautifully decorated. Many members brought their wives and the presence of the latter added greatly to the charm of the occasion. After doing justice to an excellent menu, those present had the pleasure of listening to a still better series of after dinner talks. The toast list was as follows:

"Oh, ye Gods! Ye Gods!

Must I endure all this!"—*Shakespeare.*

#### TOASTS.

Toastmaster...Dr. Woods Hutchinson  
*The President*

"A heart to resolve, a head to contrive.  
And a hand to execute."—*Shakespeare.*

*The Pulpit*...Rev. Burt Estes Howard  
"It is a good divine that follows his own  
instructions."—*Merchant of Venice.*

*The Law*.....Mr. Joseph Scott  
"To unmask falsehood and bring truth  
to light."

—*Shakespeare.*

*Commerce*.....Mr. George H. Stewart  
"By land and sea we flourish."

#### Medicine

"I have seen a medicine that's able to  
breathe life into a stone."

—*All's Well That Ends Well.*

(a) *The Doctor*....Dr. Walter Lindley  
"A wise physician skilled, our wounds  
to heal,

Is more than armies to the public weal."  
—*Pope.*

(b) *The Patient*..Dr. James P. Boothe  
"Who is my hope and my despair,  
Who keeps my body in repair,  
And takes the cash I can't well spare?"  
*The Press*.....Mr. John McGroarty  
"A chiel's amang ye takin' notes,  
And faith, he'll print it."—*Burns.*

*The Ladies*.....Dr. J. J. Choate  
"Auld Nature swears them lovely dears,  
Her noblest work she classes, O;  
Her 'prentice hand, she tried on man,  
And then she made the lasses, O."

—*Burns*

\* \* \*

"To all, to each, a fair good-night,  
And pleasing dreams and slumbers  
light."

—*Scott.*

#### SOUTHERN CALIFORNIA ANTI-TUBERCULOSIS LEAGUE.

The annual meeting of the Southern California Anti-Tuberculous League was held at the Angelus Hotel, Tuesday Evening, December 4, 1906 at 8 o'clock. The program was as follows:

Musical Selection—Glee Club of the Polytechnic High School; Introductory Remarks—Dr. H. G. Brainerd, President; Reports of Officers; Election of Officers; Musical Selection—Glee Club of the Polytechnic High School; Report of "Settlement," Redlands—Dr. C. E. Ide, Redlands; Report of Pasadena Health Camp—Dr. George E. Abbott, Pasadena; Report of Barlow Sanitarium (illustrated by stereopticon views)—Dr. George H. Kress, Los Angeles; Report of Los Angeles Helping Station—Dr. F. M. Pottenger, Monrovia; Musical Selection—Glee Club of the Polytechnic High School.

The attendance of the meeting was good and the reports of the various anti-tuberculosis activities in Southern California most encouraging.

In the absence of Dr. F. M. Pottenger, who may be styled the founder of the League, and who was detained at home by illness, the report of the Los Angeles Helping Station was made by the Secretary of the League, Dr. C. C. Browning.

The officers elected for the coming year are:—President, C. B. Boothe, Esq., of Los Angeles; Vice-President, Dr. John C. King, of Banning; Secretary; Dr. C. C. Browning, of Monrovia, Treasurer, W. C. Patterson, Esq., of Los Angeles.

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*Heat* relieves the pain of inflammation, but increases that of suppuration, although that may not prove it to be harmful.

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In *syphilitic alopecia* apply five per cent. ointment of oleate of mercury.



## CORRESPONDENCE.

## CONSUMPTION AND CIVILIZATION.

The following letter from Dr. John Bessner Huber relative to a review of his book on "Consumption and Civilization," which appeared in the September issue of the PRACTITIONER, has been received by the Editor:—

NEW YORK, Oct. 16, 1906.

To the Editor:

I thank you for the review of my book "*Consumption and Civilization*," which appeared in your September issue. I beg, in relation to it, to submit the following:

The dictum "absolute cure is a matter of many years" is Osler's. It is, in general terms, true; and it was imperative that the author of such a work should state it so. We know, however, that the patient has no occasion to be discouraged by this or to see in it a hardship, because after the first few months of his treatment all that he must do is to lead the physiological life. This should really be a satisfaction to him, for such a patient is no sufferer, but rather enjoys a sense of well being and of freedom from physical distress. He is, if he lives but normally, much better off than many another who has not been ill and who imagines that he may

with impunity subject his body to all sorts of irregularities.

The caution to the patient not to reinfect himself is not essential in sanatoria of the first rank, of which that conducted by your reviewer is a deservedly conspicuous example. But this caution is very essential under other than sanitarium conditions. Your reviewer rightly observes that "a tuberculosis patient is not necessarily dangerous; if he takes the proper precautions there is no danger in associating with him." The substance of this statement is repeatedly, redundantly and insistently set down in my book; the whole trend of the work is to this effect.

With regard to tuberculin. Your reviewer will recall that only a few years ago almost no physician would use tuberculin for diagnostic purposes upon the human subject, fearing its possible dangers, of which many experimenters made statement. Its use is now again coming into vogue—to the extent that exaggeration to the opposite extreme is to be feared. If many cases are given 10 milligrams of tuberculin, another veering of the pendulum to the first position mentioned may safely be predicted.

JOHN B. HUBER.

## BOOK REVIEWS.

**SURGERY; ITS PRINCIPLES AND PRACTICE.** In five volumes. By 66 eminent surgeons. Edited by W. W. Keen, M.D., LL.D., Hon. F.R.C.S., Eng. and Edin., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Phila. Vol. I: Octavo of 983 pages, with 291 text-illustrations and 17 colored plates. Philadelphia and London: W. B. Saunders Company, 1906. Per volume: Cloth, \$7.00 net; Half Morocco, \$8.00 net. W. B. Saunders Company, Philadelphia and London.

This magnificent volume of nearly one thousand pages is the first of five com-

panion volumes, the rest of which will be speedily issued from the press of Saunders and Company, whose imprint is sufficient guarantee of the mechanical excellence of the work.

The five volumes will represent the work of sixty-six eminent surgeons who are "the brightest, most ardent and earnest surgical scholars and experts of Europe and America."

The volume under review, divided into twenty-two chapters is the work of

thirteen surgical teachers, whose aim has been to record the very latest and established knowledge, but to note but few if any passing surgical novelties.

The editor, William Williams Keen, although we have learned to know and to love him as W. W. Keen, is a worthy successor to the long line of American surgeons who have made Philadelphia a medical centre since early colonial days:—William Shippen Jr., one of the founders of the University of Pennsylvania and Physician-General to Washington's armies from 1777 to 1781, Morgan and Rush, pillars of early medicine in Philadelphia, Phillip Syng Physick, often called the father of American surgery, a native born Philadelphian (1768), Surgeon to the Pennsylvania Hospital in 1794 and Professor of Surgery in the University of Pennsylvania in 1805 who did much to improve the technic of American surgery, William Gibson, Professor of Surgery in the same institution from 1819 to 1855, who was the first to perform ligation of the common iliac (1812) and whose book, *The Institutes and Practice of Surgery* published in 1824, subsequently demanded eight editions; John Rea Barton, born in 1794 and surgeon to the Pennsylvania Hospital, probably best known to the general profession by the association of his name with a fracture of the lower end of the radius and for Barton's bandage for fracture of the jaw (Osteotomy for ankylosis of the knee was first performed by Barton in 1826. He lived in Philadelphia until his death in 1871), George McClellan graduated from the University of Pennsylvania in 1819 and founder of the Jefferson Medical College of Philadelphia in 1824 and holding the chair of Surgery until 1838, a chair now held by the distinguished editor of the surgery under review.

Many other distinguished surgeons have maintained Philadelphia as a surgical centre but space forbids detailed mention. We cannot, however, refrain

from mentioning George W. Norris, born 1808, one of the best surgical writers of his day, Joseph Pancoast, Professor of Surgery, Jefferson Medical College, 1838, Henry H. Smith born, 1815 died 1890, Francis Maury born 1840 died 1879, who first performed gastrotomy in America, D. Hayes Agnew (1818-1892), beloved and respected by all for more than a generation, and lastly Samuel D. Gross, (1805-1884), a graduate of the Jefferson Medical College and Professor of Surgery in the School from 1865 to 1882, a great teacher, a voluminous writer, a laureate of Oxford, Cambridge and Edinburgh.

Keen, born in 1837 into this atmosphere of surgical greatness and traditions has proven a most worthy successor, and has done much to maintain Philadelphia's surgical preeminence. In his early life he was lecturer on Anatomy and Operative Surgery in the Philadelphia School of Anatomy, from 1866 to 1875, a school established in 1820 and called a "School of the Prophets" in training future professors in many departments of medicine. Later he became lecturer on Pathological Anatomy and finally Professor of the Principals of Surgery and of Clinical Surgery in the Jefferson Medical College of Philadelphia, a chair which he holds with honor to the school at the present time, a surgical environment of which he has taken full advantage.

With these qualifications for editorship he has gathered about him the first minds in surgery and they have produced a work which will stand the test of time.

There is scarcely a diagnosis made or an operation performed that does not draw heavily upon our store of physiologic knowledge, in fact the scope of physiologic surgery is very similar to surgical anatomy and surgical pathology. Thirty pages have been allotted to Crile to present the accepted knowledge in this important branch and while this space is inadequate the article is never-

theless most valuable. His remarks on acute dilatation and paralysis of the heart in surgical procedures should be read to every hospital interne upon entering upon his duties. In fact it would be well for all of us to read the entire article from time to time.

The propriety of introducing a chapter on the examination of the blood in a work of this sort may be questioned. We have hardly derived from surgical hemetology the assistance in surgical diagnosis that we all hoped for, but the work would of course be incomplete without this chapter. The hemoglobin index is of value, in fact of great value, so perhaps is the leucocyte count, iodophilia, bacteriemia, perhaps cryoscopy and the coagulation time. We have all seen the abdomen loaded with pus with a normal leucocyte count, nor does failure to culture organisms from the circulatory blood rule out sepsis. As has been aptly said we must correlate the blood report with the other clinical symptoms and then all must be sanely interpreted. In the thirty pages allotted to him Hektoon has been able to make a most valuable presentation of the study of infection and immunity as we know it to-day. I know of no clearer presentation of this obscure matter in any language. The very involved matter of antigens and antibodies is made delightfully clear. Opsonins and the opsonic index also are made clear to the general practitioner.

Adami's section on Inflammation is a classic. Compare it with the articles of eight or ten years ago and it stands forth with remarkable clearness and erudition. Every surgeon and particularly those who aspire to surgical honors should have this section at his fingers end, particularly strong as it is upon the general treatment of acute and chronic inflammation. It is a pleasure to see that so large and important a section of the book (fifty-nine pages) as that on Suppuration, Abscess, Fistula, Ulceration, Ulcers, Mortification and

Gangrene has been allotted to a Western writer, Leonard Freeman of Denver, and that the selection was a wise one, one only needs to read to decide.

So much stress has been laid in recent years upon the dependence of suppuration on the mere presence of bacteria that other important factors have largely been lost sight of, but Freeman has restored us to a more liberal attitude.

Wood's section on the process of repair is a painstaking masterly study, complete to the smallest detail and is accompanied by a most exhaustive bibliography of great value to the studious surgeon.

That the editor has chosen well in allotting one hundred and twenty-seven pages to Frazier will, I think, be conceded by all who read the carefully prepared articles on Thrombosis, embolism of various kinds, Erysipelas, Tetanus; Diseases caused by Special Infections as Anthrax, Glanders, Actinomycosis, Malignant Edema and Diseases directly derived from animals, insects and reptiles. Nothing has been omitted and all has been presented with great care and clearness.

Just why an article of six pages on Scurvy, by Frazier, should be introduced into a surgical treatise is not very clear to us. Certainly its treatment is not surgical unless the antiseptic mouth washes, so essential for the treatment of gingivitis, may be so considered.

The article on Rickets by Nichols is satisfactory in every way except that but nine lines are devoted to the surgical treatment of the bony deformities and this in a work entitled "Surgery, its principles and practice." Surgical Tuberculosis, sixty pages, by John Chalmers Da Costa is all that we would expect it to be, indeed we have gotten into the habit of expecting a great deal from this talented surgeon and he never disappoints us. It is a full presentation of the various tuberculous lesions of differ-



ent structures which demand surgical treatment.

Martin's section on Chancroid and Syphilis is one of the most complete in the volume, indeed it is entirely complete and leaves nothing to be desired. The most notable chapter in the book is that on Tumors, by John Bland Sutton. It alone would place the surgery in a class by itself and will prove of great value to that large body of the profession, the keen American surgeon in the smaller towns and cities who are only too apt to neglect the study of tumor growth on account of lack of time, limited facilities and lack of knowledge of the necessary technic.

The article is the painstaking work of a scholarly man. We are pleased to note that he considers sarcomatous degeneration in uterine fibroids as rather rare, also that fibroids are not always prone to disappear at or near the menopause. "Though fibroids as a rule, cease to grow after the menopause, it must not be forgotten that they *sometimes take on unusually rapid growth at this period*, they are often the source of great peril to life by coexisting with other serious diseases of the uterus, tubes and ovaries, while the very fact that they are apt to diminish in size is occasionally a source of danger."

The final chapter is by Crile, on wounds, contusions, shock and collapse which to one familiar with surgical literature is sufficient guarantee of its excellence. The chapter on shock and collapse should be read and assimilated by every man who does an operation, no matter how small it may be. Crile's teachings have been accepted by the entire surgical world. The mechanics of book making is seen at its best in this volume, the paper is of very high quality, the type is clear, new, and easily read. The illustrations are all a propos and many are works of art, the index is complete and replete with cross refer-

ences. No surgical library is complete without this five volume masterpiece.

WILLIAM A. EDWARDS.

STENHOUSE AND FERGUSON'S EPITOME OF PATHOLOGY. By John Stenhouse, M.D., of the University of Toronto, and John Ferguson, M.D., Toronto, Canada. 12mo., 285 pages, amply illustrated. Cloth, \$1.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1906. (Lea's Series of Medical Epitomes. Edited by Victor C. Pedersen, M.D.)

This is one of the best volumes of this series and the task of presenting in brief compass a fairly complete survey of the domain of pathology is quite well done. The general arrangement, diction and typographical work are all good.

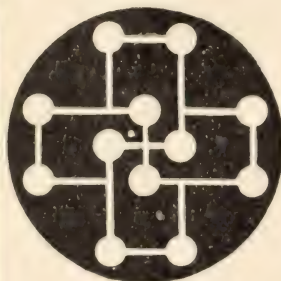
GENITO-URINARY DISEASES AND SYPHILIS. By Henry H. Morton, M.D., Clinical Professor of Genito-Urinary Diseases in the Long Island College Hospital; Genito-Urinary Surgeon to the Long Island and Kings County Hospitals, and the Polhemus Memorial Clinic. Illustrated with 158 half-tone and photo-engravings and 7 full-page colored plates. Second Edition, Revised and Enlarged, Royal Octavo, 500 pages. Bound in Extra Cloth. Price, \$4.00 net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

This is a well-written treatise on a very important branch of medicine and surgery, in fields where much progress has been recently made. In this second edition of Morton's book, especial attention is paid to the pathology and operative procedures connected with inflammatory and hypertrophic conditions of the prostate gland.

A TEXT-BOOK OF HUMAN PHYSIOLOGY. By Dr. Robert Tigerstedt, Professor of Physiology in the University of Helsingfors, Finland. Translated from the third German Edition and edited by John R. Murlin, A.M., Ph. D., Assistant Professor of Physiology in the University and Bellevue Hospital Medical College, New York City, with an introduction to the English Edition by Professor Graham Lusk, Ph. D., F.R.S. (Edinb.) New York and London. 752 pages. D. Appleton and Company, 1906.

Tigerstedt brought out his first edition of his "Lehrbuch der Physiologie

## Crude Mechanical Processes



are powerless to aid the digestion of fats. According to Dr. N. S. Davis, Jr., emulsions "made by mechanical processes or by simple suspension of the oil in fluids thickened with gum arabic, sugar, and other viscid substances, do not aid digestion. An emulsion made with pancreatic extract may do so."—*Cohen's Sys. of Physiologic Therapeutics*.

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des Menshens" in 1897, and since that time three editions have been issued, the last being translated into the English by Murlin of Bellevue. This excellent text book on physiology is particularly strong in his discussion of the phenomena of the circulatory, respiratory and nervous systems and of the changes incident to metabolism generally. The subject matter is approached from the biological view point and is dealt with in a broad and scientific spirit. The typographical arrangement is excellent and the print clear and on good paper, and the 305 illustrations and diagrams add greatly to the value of the work. There was certainly abundance of reason for translating this work into the English and it will probably have a wide use among students. We know no re-

cent work which is so well adapted to the needs of the practitioner who would review, or have handy for reference, a volume in which can be found the latest advances and researches concerning the normal functions of the body tissues and viscera as this now-old book of Tigerstedt.

BLAKESTON'S QUIZ COMPEND. A Compend of Genito-Urinary Diseases and Syphilis including their surgery and treatment. By Charles S. Hirsch, M.D., Assistant in the Genito-Urinary Surgical Department, Jefferson Medical College Hospital. Illustrated. Cloth, 361 pages, \$1.00, Philadelphia, P. Blakeston's Son & Co., 1312 Walnut Street, 1904.

The author of this work has crowded in compend form a vast deal of information, and in terse and clear style, has given an excellent survey of this

important branch of medicine and surgery. Though called a compend, it is something more for it is of sufficient breadth to serve well the purpose of a handy reference book. It is more than worth its price.

**SAUNDERS' POCKET MEDICAL FORMULARY.** By William M. Powell, M.D., author of "Essentials of Diseases of Children;" member of Philadelphia Pathologic Society. Containing 1331 formulas from the best-known authorities. With an appendix containing Posologic Tables, Formulas and Doses for Hypodermic Medication, Poisons and their Antidotes, Diameters of the Female Pelvis and Fetal Head, Obstetric Table, Dietlists, Materials and Drugs used in Antiseptic Surgery, Treatment of Asphyxia from Drowning, Surgical Remembrancer, Tables of Incompatibles, Eruptive Fevers, etc., etc. Eighth Edition, adapted to the New (1905) Pharmacopeia. Philadelphia and London: W. B. Saunders Company, 1906. In flexible morocco, with side index, wallet and flap. \$1.75 net. W. B. Saunders Company, Philadelphia and London.

Medical formularies have a wonderful interest to medical students, and the popularity of this type of book is indicated by the fact that this is the eighth edition of Powell's little work. This new edition has been adapted to the 1905 Pharmacopeia. In addition to the former contents, almost 500 prescriptions, culled from the best works and writings, and embodying the newer remedies, have been included. In serving its special purpose, the book is one of merit.

**DIET IN HEALTH AND DISEASE.** BY Julius Friedenwald, M.D., Clinical Professor of Diseases of the Stomach in the College of Physicians and Surgeons, Baltimore; and John Ruhrah, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. Second Revised Edition. Octavo of 728 pages. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$4.00 net; half morocco, \$5.00 net. W. B. Saunders Company, Philadelphia and London.

There have been published in recent years many books on dietetics, some good, some poor, all however, striving to fill a want felt by many practitioners, who in their student days, heard little concerning diet, as a factor in the

therapy of nearly all disease states. The importance of elimination is recognized by all, but the relation of a faulty elimination to a faulty assimilation, dependent in turn upon improper and poorly prepared food-stuffs, this factor is not given the recognition it should have, either in the curricula of our medical colleges, or in actual practice at the bedside.

To understand pathology one must know physiology well. To order a diet in disease, it is important to understand the value of different diets in a state of health.

It is possible to write a vast deal concerning the various kinds of food-stuffs, but to present those items of scientific and practical interest, requires considerable discrimination.

Friedenwald and Ruhrah have accomplished this task in an exceptional manner and present a book of comprehensive scope, written in clear manner, and giving concise and explicit directions concerning the kinds of food, their value and their mode of preparation, as parts of the diet to be followed in different diseases. The work is worthy of commendation and will be sure to find many friends.

**PROGRESSIVE MEDICINE.** A quarterly digest of advances, discoveries, and improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; physician to the Jefferson Medical College Hospital; one time clinical professor of Diseases of Children in the University of Pennsylvania; member of the Association of American Physicians, etc. Assisted by H. R. M. Landis, M.D., visiting physician to the Tuberculosis Department of the Philadelphia Hospital, to the White Haven Sanatorium and to the Phipps Institute; demonstrator of Clinical Medicine in the Jefferson Medical College. Volume II., June, 1906. Hernia, Surgery of the Abdomen, exclusive of Hernia Gynecology, Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland, and Lymphatic system, Ophthalmology. Lea Bros. & Co., Philadelphia and New York, 1906.

The June number of *Progressive Medicine* for 1906 contains articles on Her-



nia by Wm. B. Coley, Surgery of the Abdomen by Edward Milton Foote, Gynecology by John G. Clark, Diseases of the Skin by Alfred Stengel and Ophthalmology by Edward Jackson. The names of these foregoing contributors insure the standard for the present volume.

In his article on Hernia, Coley, after calling attention to the necessity of restoring the normal obliquity of the canal as based upon the operations of Marcy, Bassini and Halstead, states that he believes the underlying cause of Inguinal hernia in a great majority of cases is a pre-existing sac of congenital origin.

With regard to infecting the wound, he states that within the last seven years, that is since the time that rubber gloves were introduced, in his own experience he has found infection to occur in less than one per cent. of his cases. He says: "Personally I do not believe that there is any more probability of suppuration occurring after Bassini's method than after Woelfler's." He further says: "I have operated upon two hundred consecutive cases with one suppuration, and in this case there was no relapse."

Coley quotes Bodine, of New York, who operates largely under local anesthesia as saying: "That the anatomy of the inguinal region is so constructed in accessibility, regional restriction, paucity of blood vessels, and above all in sensory nerve supply, as to make the operation in question the most favorable in general surgery for local anesthesia." He furthermore states "that in strangulated hernia, with profound shock and toxaemia, this method finds an imperative application."

On page 240, Stengel remarks upon what Langdon has styled "pre-pernicious anemia." With regard to this term, Stengel agrees with Wolfstein that the adoption of this name would lead us into difficulties, for he thinks the clinical picture of pre-pernicious anemia is

well enough established to diagnose it without supposing a precursory stage.

Under the subject of Leucocytosis, Stengel remarks that Brown, in *American Medicine*, Nov. 4th, 1905, "believes after reviewing the literature concerning the theories of white blood cells in health and disease, that a thorough appreciation of the exact significance of leucocytosis will not be possible until we have definitely determined the mode of origin of the various forms of white blood cells, and the relationship to each other. However, it has provided the surgeon and gynecologist with the ready means of determining whether or not he is dealing with inflammatory or suppurative processes, whether the process is diminishing or increasing, and tells him much regarding the prognosis of cases."

On page 310, the treatment of diabetes is considered. The so-called "milk cure," "potato cure," and "oatmeal cure" are discussed. He quotes Ruhrah and Friedenwald as saying, "that they have never seen the slightest harm produced by potatoes even in the severest form of diabetes, if care was taken to regulate the proportions. In a number of cases very beneficial results were obtained. The results with the oatmeal diet were satisfactory. These articles should never be utilized in mild forms, but only in the severe forms."

This line of treatment is quite in accord with the latter-day theories of sustaining the bodily weight of patients in severe cases of diabetes rather than to try to reduce the amount of sugar secreted

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EATING TO LIVE, WITH SOME ADVICE to the Gouty, the Rheumatic, and the Diabetic. A Book for everybody. By John Janvier Black, M.D., Member of the College of Physicians of Philadelphia; Member of the Delaware State Medical Society; Author of "Forty Years in the Medical Profession," "Cultivation of the Peach, Pear, Quince, and Nut-bearing Trees," etc. "Many People Dig Their Graves with Their Teeth."

J. B. Lippincott Company, Philadelphia and London, 1906.

This is a very useful volume of over 400 pages. Dr. Black is probably the best qualified man in the United States to give instruction in this subject. In speaking of beverages the author says: "In tea Great Britain leads—about six pounds per person per year. We use about one and a half pounds per person. Russians use only nine ounces per person per year, and yet they are supposed to be a tea-drinking people. Here we see the condition as shown by diet—the masses being too poor to drink much tea. Of coffee the Netherlands use the most, over twenty-three pounds per person per year, whilst we in the United States use nearly twelve pounds and England uses only one-fifth of a pound. Russia uses only three ounces per person per year.

In malt liquors Great Britain takes the lead—thirty gallons to each person per year, actually leading Germany by three gallons per person. We use eighteen gallons per person per year. In the wine-drinking countries comparatively little is used, although it is increasing in France, she now using six gallons per person per year. Spain uses only a little over one pint, but in wine consumption Spain leads the world—thirty-five gallons to each person per year. France uses twenty-nine gallons, and Italy, twenty-four gallons. It is interesting to note that the United Kingdom uses less than two quarts of wine per person per year. Her climate demands something stronger. Surprising to say, Germany uses only a little over one gallon of wine per person per year. In the United States the consumption of wine is rapidly increasing, but it is yet only two quarts to each person per year, making the respectable quantity of thirty-eight million gallons. Russia and Great Britain and her colonies are among the great spirit-drinking countries, and climate here is the great factor in determining the quantity con-

sumed. Some recent statistics from Washington are both gratifying and surprising. They show that the amount of distilled liquors consumed by the people of the United States per capita has dropped from 2.5 to 1.48 gallons annually, but even now we use more ardent spirits than do the English, the French, or even the Russians, who, according to statistics, scarcely deserve the name of hard drinkers."

This reduction in the amount of whiskey and brandy used in the United States is certainly very gratifying.

We heartily commend the work.

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CONFERENCES ON THE MORAL PHILOSOPHY OF MEDICINE. Prepared by an American Physician. "Nil dictum quod non dictum prius," Rebman Company, 1123 Broadway, New York. Rebman Limited, 129 Shaftesbury Ave., W. C., London.

This is a scholarly, philosophical volume in a field that has not been cultivated. It will help the physician to not only do his duty but also to be a gentleman. The author sums up his idea of the true physician as follows:

"Virtue, knowledge, health, and activity are the primal sources of felicity of the student and physician.

Moral rectitude, untiring industry, natural aptitude, and quick perceptions are the highest attributes of the genuine student and physician.

The advancement of science, justice tempered with mercy and generosity, fidelity to duty, hope of lasting usefulness, and charity toward humanity, are the noblest aspirations of the true physician."

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HOW TO SUPPRESS A MALPRACTICE SUIT, AND OTHER MEDICAL MISCELLANIES. By Thomas Hall Shastid, A.M., M.D., LL.B. Marion Publishing Co., Marion, Illinois, 1906. Price \$1.50.

The author dedicates this book "to the Physicians of America, often overworked and almost always underpaid, yet in daily danger of losing all—house, home, even professional reputation—through the inability of untrained juries

to comprehend medical science, in the sincere hope that some time, somewhere, it may prove to be the means of professional salvation to some struggling and legitimate doctor."

This is a practical little work written in a bright and interesting style.

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INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on Treatment, Medicine, Surgery, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners, by leading members of the medical profession throughout the world. Edited by A. O. J. Kelly, A.M., M.D., Philadelphia, U. S. A., with the collaboration of Wm. Osler, M.D., Oxford; John H. Musser, M.D., Philadelphia; Jas. Stewart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, Toronto; Thos. M. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; Jas. J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels, and Cernisbad. Volume III. Sixteenth series, 1906. Philadelphia and London, J. B. Lippincott Company, 1906.

This volume is divided into The Treatment of Acute Pleurisy from pages one to thirty-five, General Medicine to one hundred and thirty-three, Surgery to page Two hundred and thirty-eight, Rhinology to two hundred and seventy-one, Otology to two hundred and eighty, and a closing article on Leukemia and Sarcomatosis by Banti, of Florence, Italy.

In the list of contributors to this volume we see Carmichael, of Edinburgh; Gregor, of Glasgow; Pinard, Saingery, and Soupault, of Paris, together with some of the most noted men in the American profession.

Saingery, of Paris, recounts Prof. Fournier's recent modification of his treatment of syphilis. Fournier, in his later years, takes the ground that long and careful treatment by mercurials presents no safeguard to the development of paresis later in life. On page thirty-four

he says: "In a word: (1) It is materially impossible to prove that a syphilitic patient who escapes paresis owes this to the mercury he has taken. (2) It has been absolutely demonstrated that any amount of mercury does not always preserve a patient from paresis. Consequently, the administration of mercury as a preventive of general paralysis in a syphilitic patient cannot be logically upheld; its use in this sense is not a direct or strict inference from facts, but is based on hypotheses dependent on the 'impressions' caused by facts, impressions that are controverted by still other 'impressions' and hypotheses."

On page one hundred seventy-four, Charles Green, of Boston, presents a very interesting article of some fifty pages on Peritoneal Adhesions, an article which should be interesting to all abdominal surgeons.

The work holds throughout its usual excellent standard, and that standard is such that to the medical man who is constantly at work, and unable to take post-graduate courses finds, in the work material which to a great degree, if well followed, supplies the lack of such courses.

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STUDIES IN THE PSYCHOLOGY OF SEX—EROTIC SYMBOLISM, THE MECHANISM OF DETUMESCENCE, THE PSYCHIC STATE OF PREGNANCY. By Havelock Ellis. 6 1/2 x 8 1/2 inches. Pages x-285. Extra Cloth, \$2.00, net. Sold only by Subscription to Physicians, Lawyers, and Scientists. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia.

This series comprises the most authoritative and complete treatise on the Psychology of Sex in the English language.

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Hamamelis and pure glycerin, one part to two, and used as a lavement, gargle or spray, is said to be a valuable remedy in *catarrhal affections of the air passages*.











